

# **Accommodation Options for Older People in Aotearoa/New Zealand**

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## **Executive Summary**

### **The importance of housing for older people**

The ageing of the population will have significant implications for society and for the economy as a whole. Ensuring the wellbeing of older people will be a challenge, as the age composition of the population changes, requiring attention to be given to groups of older people who are especially vulnerable or disadvantaged. Housing ranks high among the factors which influence wellbeing, thus the availability of suitable accommodation to meet the needs of an ageing population is a central issue for policy and planning in all sectors.

The report incorporates information from the present situation, projections for the future, international examples and informed opinions from stakeholders in the housing sector. It uses these to look to the future and ask what types of accommodation will best meet the needs of a rapidly ageing New Zealand population and improve the quality of life for older people, especially those with low incomes, renters, Maori, Pacific people and women.

Housing plays a variety of roles in people's lives. As well as providing shelter it is a form of investment and contributes to economic, social and psychological security. These latter 'intangible' factors can be at least as important as the tangible and monetary costs and benefits of different housing options. Housing conditions influence both physical and mental health, but the inter-relationship is not simple. The important intervening variables are income and housing tenure. Maori or Pacific ethnicity and female gender are additional factors, operating through income levels and earning opportunities.

### **Characteristics of older people relevant to their housing**

The New Zealand population is ageing, but within the older population it is the older age groups that are increasing most rapidly, as a result of increased life expectancy. Life expectancy is higher for women than for men, and thus women predominate among the older population. However, this brings with it the likelihood that women will experience more years with a disability at the end of their lives. Life expectancy and marital patterns result in more women being unpartnered in late life and more women living alone. These factors combine to underline the vulnerability of older women and to suggest that their needs be given a high profile in the planning and designing of housing for older people.

Overall the households of older people are small, comprising mostly single people and older couples. The proportions living in such households have been increasing. This applies also to Maori, despite the traditional preference for extended family living. A high proportion of older Pacific people, however, continue to live with their kin. Living arrangements and household composition also affect housing demand.

Despite the fact that people are living longer and staying healthier, rates of disability and ill-health increase with age. A very small proportion of older people under the age of 80 live in residential care. Entry into residential care is occurring later in life and at higher levels of disability. This means that a growing proportion of older people with special needs for care and support are remaining in the community, in mainstream housing or accommodation specially for older people.

Average incomes for people 65 and over are lower than for younger people, related to levels of workforce participation. Incomes, and sources of income, differ by gender and ethnicity. The incomes of women are lower than those for men right up to the oldest age groups and women are less likely than men to enjoy supplementary sources of income, over and above New Zealand Superannuation. Older Maori and Pacific people also have lower incomes than older Pakeha. These income patterns strongly influence the housing situation of different groups of older people, the extent to which they are able to accumulate housing assets, and the opportunities which they have to fulfil their housing needs.

## **The current housing situation of older people**

Most older people in New Zealand live in private dwellings as opposed to institutions (residential care). The oldest age groups are over-represented in smaller housing units and in multi-unit dwellings. Mortgage-free homeownership is high among older people, but varies by ethnicity. Over the last ten years there has been a decline in homeownership among older Maori and Pacific people. This is less evident for the Pakeha group, but falling levels of homeownership among people in mid-life raise questions for the future.

A minority of older people rent their accommodation, from, in order of numerical importance, private landlords (which include voluntary organisations), Housing New Zealand Corporation (HNZC) or local authorities. The proportion of people renting privately decreases with age, as does the proportion with HNZC. The proportions renting from local authorities and from

trusts, on the other hand, increase with age. These patterns apply to both men and women. The main difference by gender is that older men are more likely to rent privately than older women and the reverse is true for renting from HNZC. This may relate to differences in income. Older Maori and Pacific people are more likely to be renting than older Pakeha and a high proportion of older Pacific people rent from HNZC.

Renters, especially local authority tenants, are more likely to fall into the low household income group than homeowners. But in numerical terms there are more owners than renters with low incomes. Owner-occupiers clearly have much lower ongoing housing costs once they have paid off their mortgages, leaving more income to fulfil other needs. Tenure is clearly an influential factor in differentiating between groups of older people. It is linked closely to income and asset accumulation and also to other factors such as security of housing tenure, housing quality and socio-economic status (and also with health status).

## **Current housing options and issues**

There is a group of older people (mainly homeowners) who have a range of accommodation options open to them. But for another group of older people (mainly non-homeowners and low-income homeowners) options are limited.

Older people who own their homes still face issues of maintenance, adaptation and renovation. For low-income homeowners such outlays may be delayed or deferred, thereby reducing the quality of their housing. Current assistance in these areas is limited. Increasing rates charges create financial stress in many areas and the rebate scheme provides little relief. Homeowners can mobilise equity tied up in their homes through trading down and also by using equity release schemes, although these are not well developed in New Zealand. Retirement villages offer an option for older people with sufficient assets.

Public sector pensioner housing stock was mainly built several decades ago, much of it is in need of upgrading and may also be unsuitable for current requirements, being dominated by small units and bed-sitters. These comments also apply to kaumatua flats, developed through the former Department of Maori Affairs. HNZC is committed to upgrading and extending housing for older renters, in partnership with other agencies and some funding is on stream. Local authorities differ in their policies towards housing for older people. Some have divested themselves of their housing stock, while others are upgrading and committed to expansion. The private rental market is fragmented and tends to be associated with lower

quality housing, although this is where the largest group of older tenants is to be found. Public and private landlords do not usually offer care and support services along with housing for older people. In New Zealand, this is the sphere of voluntary agencies, generally religious and charitable groups. There is a range of such providers, often managing housing developments which incorporate both home-based and residential care. These, and some local authority pensioner housing clusters are the closest local options to sheltered housing, in the European sense.

## **International models and concepts**

In the international arena there are a range of schemes intended to support 'ageing in place' and to improve the quality of the housing environment for older people. These include design guides and quality marks, smart and assistive technology. In many countries governments fund agencies to assist with home improvements, home-sharing and to help older people in moving from one type of accommodation to another.

If people choose to move, there are two broad approaches to housing appropriate for older people - dwellings 'pepper-potted' within the wider community or clustered together as a 'village'. The former include CoHousing, in which groups of people join together to create and manage their accommodation; secondary accommodation options, such as granny flats; sheltered accommodation, which is well developed in Britain and benefits from an externally validated Code of Practice; and extra care housing. In this last model people needing high levels of care can retain autonomy and community contacts.

'Villages' for older people may be self-contained retirement communities along the lines of retirement villages, which are common in New Zealand, Australia and North America, or they may take the form of 'social villages'. These seek integration with the wider community and may provide the 'hub' for service provision to older people in mainstream housing. This model does not cut older people off from inter-generational contacts and can reflect different ethnic and cultural traditions.

Timely and accurate information is essential if people are to explore their housing options and exercise informed choices. There are examples from the USA and Australia of on-line 'clearinghouses' which meet those information needs.

## Future trends, scenarios and risks

Population projections confirm that the ageing trend will continue up to the middle of the century and that growth will be particularly rapid for the age group 85 and over. Numerical growth in the older Maori and Pacific populations will be significant, although, unless there is an extension of life expectancy for these groups, numbers in the 85 plus age range will remain low. There will be increased demand for housing of all types, but special challenges for providers of rental accommodation. These will apply especially if levels of homeownership continue to decline.

Assumptions about the distribution of older people between owning and renting, between different rental sectors, and between residential care and community living influence the demands which will be placed on government expenditure in the future.

A *no change* scenario would see a doubling of numbers of older people in residential care by 2021. But a reduction in residential care provision, resulting from ‘ageing in place’ policies, will bring considerable savings in Vote:Health. Such a reduction would need to be matched by adequate community-based options in terms of both housing and care. Such options could be funded by resources which have been freed up.

The *no change* scenario also indicates a potential shortfall in the number of rental homes available in the public sector. The choices are: a supply-side response (acquire more houses to add to the public housing stock to cope with the additional demand); a demand-side response (attempt to change/modify behaviour to alleviate the shortfall); or a combination of both of the above.

There are costs and benefits from both the individual and government perspectives in the scenarios generated. Housing options to support older people to remain living in the community will produce significant fiscal benefits. These could include investment in home maintenance for homeowners and tenants. If poorly maintained housing is impacting on the health status of older people, there is a ‘public good’ argument for government to assist. Such intervention could lead to significant health savings and improve wider wellbeing.

The primary risk surrounding the future projections relates to the *no change in tenure patterns* assumption. Given recent declines in homeownership rates and affordability, this assumption could be seen as somewhat optimistic. Lower levels of homeownership will increase requirements for public sector rental accommodation for older people even further. This

reinforces the need to explore the range of measures on both supply and demand sides in order to mitigate this risk.

## **Issues for the future**

The international review of housing options and concepts highlights a range of cross-cutting issues, relating to the processes of evaluating, creating and managing the housing options for older people, as we look to the future. These include a range of requirements to support ageing in place. Foremost among these are measures to ensure that housing is adequate and appropriate to enhance the wellbeing and health of older people, while also promoting independence, choice and social contact. These should acknowledge diversity in the older population, and a range of aspirations based on lifestyle, health and disability status, cultural contexts, gender and personal circumstances.

New and developing concepts warrant examination for their appropriateness in the New Zealand context. These include equity release schemes, new forms of tenure such as shared ownership, and emerging technologies. This country could learn from the experience of others who have travelled further down the ageing track – in terms of the physical aspects of housing, the form and location of housing developments for older people. In a more specifically local context, the special needs of older Maori and Pacific people require attention. These groups share the aspirations of older people in general for housing which is comfortable, warm, safe and accessible, located close to amenities and which helps to preserve family and community contact. However, special cultural requirements and the preference to live with other older Maori and Pacific people suggest that the ‘social village’ model would be appropriate for many people in these groups.

Policy issues are raised concerning who should take responsibility for developing housing for older people. What are the roles of individuals and families, central government, local authorities, health authorities, voluntary agencies and the private sector? And how could these sectors work together to meet housing needs and to ensure the provision of support and care services that are so closely bound up with housing for older people? If new developments and new programmes come into being, there are ongoing management issues, foremost among which are resident/tenant participation, eligibility criteria and quality control (relating to both housing and care services).

As well as the need for information services, there is a need for advocacy to ensure that

vulnerable groups of older people have voice and choice in matters related to their wellbeing. Attitudinal factors are important, but these may change as oncoming cohorts move into later life. This suggests the need for flexibility and awareness of diversity, including the variety of roles which older people play in communities and society. We need a variety of responses to housing and care needs, which may reflect the 'continuum' concept being applied in the context of health care policies.

## **Implications and conclusions**

There is no single housing option which can be recommended to meet the future needs of older New Zealanders. Nor can housing be seen in isolation from other elements which contribute to the wellbeing of older people, although it is a crucial influence. For very old people, in particular, housing needs cannot realistically be separated from care and support requirements. These imperatives are recognised in current policy, especially in the Positive Ageing and Health of Older People Strategies.

Ageing in place is clearly a favoured approach in New Zealand government policy, and more widely. But staying in a long-term family home may not be the best option in all circumstances. Specialised housing, in the form of sheltered or extra-care housing, retirement villages or social villages will be part of the mix. Nevertheless it is likely that the vast majority of older people in the future will be 'ageing in place' rather than in institutional care. It may be more economic to renovate existing housing than to build specialised housing for older people, to cope with the increased demand fuelled by population ageing.

The prospect of developing partnerships between public, private and voluntary sector agencies is a promising avenue to explore. This may avoid the 'silo' approach to policy development and delivery and help to coordinate activities.

The information arising from this research suggests that improving the housing situation of older people, especially renters, and those in low income and other disadvantaged groups, will have a beneficial effect on their health, in the widest sense, and lead to a more resilient older population, as well as contributing to the objectives of current government policies.

There are two challenges. The first is to maintain and upgrade the living conditions of older people in mainstream housing so that 'ageing in place' remains viable and becomes increasingly so. The second is to develop a range of alternative housing options to meet

special needs, whether these be care needs, social or cultural preferences. These measures should target older people who lack the personal and financial resources to ensure adequate and appropriate housing without external assistance.

Housing which contributes to the wellbeing of older people is important to the whole community, not only because all will grow old, but also because the amount of government spending on income support and services for older people influences the resources available for other areas. From the government's perspective, efficient allocation of resources is important, within the policy framework that seeks to improve wellbeing for all.

## Introduction

Population ageing is one of the most significant issues facing New Zealand. Its implications are crucial for government and will affect individuals, households, communities, government business and voluntary organisations. An in-depth knowledge of factors that promote wellbeing in later life is fundamental to successful social and economic adjustment as the age composition of the population changes. The availability of suitable accommodation to meet the needs of an ageing population is part of this challenge, recognising the important part which housing can play in the quality of life of older people. The report is based on the belief that having secure and comfortable accommodation of an appropriate quality will deliver physical and psychological benefits to older New Zealanders and will result in a healthier and more resilient older population.

While housing for an ageing population is an important general issue, there is special concern for the housing and care needs of vulnerable groups of older people – those on low incomes, those suffering from chronic illness or disability, and those whose housing conditions are currently inadequate. The special needs of older Maori, Pacific people and women must be addressed to meet equity and Treaty responsibilities. Hence the research focuses on people aged 65 plus in the following groups:

- People living in the community (including people living in retirement villages and pensioner housing, but not those in full-time institutional care);
- Those with little significant personal income above the level of New Zealand Superannuation (NZS);
- Renters in the public and private sectors;
- Older Maori, Pacific people and women.

The central question to be addressed in this report is therefore:

What would be an appropriate mix of short and long term public and private accommodation investments that will meet the needs of a rapidly ageing New Zealand population and that will improve the quality of life for older people, especially those with low incomes, Maori, Pacific people and women?

The information included in this report will assist public sector agencies concerned with housing for older people in their policy development and forward planning. It will also be

valuable for private and voluntary sector organisations. A multi-disciplinary and context-based approach has been adopted and the report indicates where partnerships between public, private and voluntary sector agencies might be beneficial – thus supporting ‘whole of government’ and ‘partnership’ approaches.

## **Outline of the Report**

The report begins by placing the study in its policy context. Chapter 1 then outlines general issues relating to housing for older people, including the relationship between housing and health. The characteristics of older New Zealanders and their current housing situation, with special reference to the target groups, is covered in Chapter 2. Chapter 3 presents examples of housing options and housing-related concepts from New Zealand and from the international literature, which are likely to be useful here and/or are worthy of extension. Future trends relevant to housing are set out in Chapter 4, with projections of population and housing demand and a forward-looking economic analysis. Chapter 5 also looks to the future, examining a range of cross-cutting issues. Finally, Chapter 6 brings together the findings of the study and explores their policy implications.

## **Methodology**

In order to provide a factual basis for the analysis of future options, the study began with a scoping phase, from November 2003 to February 2004. This brought together data on the current housing situation of older people in New Zealand, analysing their general characteristics, dwelling types, incomes and household tenure. The information fed into a cost/benefit analysis of the current housing models ranging along a continuum from independence to dependence. The scoping phase also included a review of international literature to identify relevant issues and innovative strategies for housing older people.

Information from the scoping studies, and the original research proposal, generated questions for the consultation phase of the project, which took place from March to May 2004. Sets of questions were developed for central and local government, for voluntary agencies, for Maori and Pacific communities (Appendix 1). Appendix 2 lists the people and individuals who were consulted and discusses the processes adopted.

The third stage of the study was a synthesis of material drawn from the wide range of sources already outlined, focusing on models of housing for older people, and issues related to them,

which are likely to be appropriate in the New Zealand context, given the trends identified. A range of stakeholders had the opportunity to comment on these models, and issues related to them, at two round table meetings in early June. These discussions also helped to inform the findings of the study and the policy implications which have been drawn out.

In line with the multi-disciplinary approach mentioned above, the two research organisations – NZiRA and BERL – worked closely together at every stage of the project. In addition, collaborators provided specialised input from the Maori and Pacific Island perspectives and case studies have been used to give in-depth examples, by region and by sector.

## **Policy Relevance**

The research is relevant to several current policy initiatives.

### *Positive Ageing Strategy (2001)*

#### *Goal 3 – Affordable and appropriate housing options for older people*

The strategy aims to encourage and assist older people to remain in their own homes, in order to enhance their sense of independence and self-reliance. Integrated and appropriately delivered support services will help alleviate feelings of vulnerability, isolation and insecurity. The strategy calls for the assessment of the effectiveness of service provision – what works best to adequately support older people to remain safely in their own homes and what influences whether or not an older person requires residential care.

### *Health of Older People Strategy (2001)*

The strategy proposes an integrated approach to health and disability support services which is responsive to varied and changing needs, which supports older people remaining in their own homes, and reduces the need for institutional care. It emphasises the ‘integrated continuum of care’ approach, which has informed this research. It calls for health-related services to be coordinated with services from other sectors, such as housing and transport. The physical health benefits from living in high quality and appropriate accommodation are likely to be significant. There are also psychological benefits from high standards of housing, security and independence.

### *New Zealand Housing Strategy (forthcoming)*

The principles of the draft strategy place emphasis on housing quality, the integration of housing with other services, diversity and choice, anticipating change, Maori responsiveness, and partnership. All are consistent with Health and Positive Ageing Strategies and all have informed the current study. In 2002, the Older Persons Housing Working Party met as an input to the strategy. The group formulated goals which relate closely to the Positive Ageing Strategy, including ageing in place, community involvement, the recognition of diversity, linkages between housing and health and social support services. The group also supported the exploration of alternative models of housing for older people.

### *Treaty Obligations*

The Crown has obligations to Maori, under the Treaty of Waitangi, in the housing area. These include ensuring that older Maori receive the appropriate economic and social support and have suitable accommodation (in terms of type, location and in relation to cultural needs).

### *Sustainable Communities*

Older people can and do make a very important contribution to the communities they live in. Making it easier for older people to remain in the community, in their homes or appropriate housing facilities, will strengthen communities (and is consistent with the Positive Ageing Strategy).

Specific reference to maintaining the independence of older people and protecting them from risk, as well as encouraging their full participation in the community is made in the *NZ Disability Strategy (2001)*, the *Transport Strategy (2002)* and the *Injury Prevention Strategy (2003)*.

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## **Chapter 1.**

### **Important issues in housing for older people**

Housing performs a variety of functions in society as well as providing shelter. It is a capital investment for individuals and families, an important sector of the economy, and it contributes to both psychological and financial security. Recent studies have found that older people see 'home' as a place of security and refuge, a place where they can express their individuality, retain control over their lives and remain independent (Keeling 1999, Smart and Means 1997, Tinker et al 1999). All of these aspects of housing need to be considered when examining housing in an ageing population.

### **Ageing in Place**

In New Zealand a high proportion of people remain in their own homes until the end of their lives. This is termed 'ageing in place' and has been a favoured concept as governments and international bodies look to the future. In 1994, the health and social policy ministers of OECD countries reached an agreement on the overall objective of policies towards the care of frail elderly people, that is 'elderly people, including those in need of care and support should, wherever possible, be enabled to continue living in their own homes, and where this is not possible, they should be enabled to live in a sheltered and supportive environment which is as close to their community as possible, in both the social and geographical sense' (OECD 1994). There is a general conclusion that traditional institutional care which keeps older people apart and medicalises old age is no longer desirable and most OECD countries are committed to reducing numbers of people living in institutions (OECD 2003 p11). 'The ageing process should no longer be viewed as an inevitable economic and social isolation from the rest of the community (OECD 2003 p173). 'Ageing in place' is linked to 'positive' ageing and an approach, through lifestyle choices, involvement and activity, that seeks to counter negative perceptions of ageing and retirement.

This emphasis on 'ageing in place' implies that older people will remain in the community, either in their family homes, in homes to which they have moved in mid or later life, or in supported accommodation of some type, rather than moving into residential care. It also tends to imply living independently of other family members. There has been a decrease in intergenerational living in most developed countries, even for frail older people (OECD 2003). This acknowledges that living in larger households does not necessarily eliminate

loneliness and social isolation. The policy emphasis on ageing in place is reflected in the personal preferences of older people themselves, who tend to support 'intimacy at a distance' with their families. This emerged from consultation forums with older people held to contribute to the New Zealand Housing Strategy discussion paper (HNZC 2004 p61.) These preferences provide strong support for ageing in place policies.

As part of activities in the International Year of Older Persons, the Senior Citizens Unit and the Ministry of Social Policy carried out a study of the factors affecting the ability of older people to live independently (Dwyer et al 2000). The study pointed out the social, economic and service requirements if people are to age positively 'in place' and noted that living independently does not simply mean living at home. It implies access to services and resources which ensure a good quality of life despite age-related illness or disability. These include family support and care and the provision of home-based services through public, private or voluntary sector agencies. At the same time - 'Well designed, easy to manage, affordable, warm and safe housing is as important to independent living as inputs of care' (Dwyer et al 2000).

Ministerial briefings in 2002 further pinpointed key factors in ageing in place, including both personal and environmental factors.

There are a number of factors that influence an older person's capacity to maintain independence. These include personal health, income adequacy, safety and security, access to community-based support or social services, and mobility. For many older people the key to maintaining independence is remaining in their own home. (NZ Government, 2002).

For older owner-occupiers remaining at home may depend on their ability to have their houses modified, adapted or maintained in order to keep them in good condition and able to fulfil their needs. Most housing has not been designed with older age and impairment in mind and the arrangements of the home environment often inhibit the ability of a person to manage their daily life. Deficiencies in housing may reinforce dependency and increase pressure on support agencies (Harrison and Davis 2001). Hence the emphasis on appropriate design and development of the lifetime home concept so that housing can accommodate the needs of people throughout the lifespan (Tinker et al 1999).

Thus, an important aspect of ageing in place is the ability of older people to make

modifications and repairs to their homes so they are able to remain living there safely (Heywood et al 2002). However, maintaining a property to a reasonable standard can be difficult for older low-income homeowners. In the British context, Heywood et al (2002) found that even though older people often live in poor conditions and accept these, this should not be seen as ignorance or indifference. Often the situation arises because the older person has developed a tolerance of housing defects; through their inability to undertake the repair work themselves, the high cost of employing professionals, fear of disruption and exploitation, and a feeling that the cost of the repairs is a waste of money ‘at their time of life’. However, these conditions might ultimately threaten wellbeing and health and lead to premature entry into residential care. In addition, there is the wider economic issue of the cost incurred through inadequate maintenance of the housing stock.

## Moving house in later years

Some older people do elect to move from their family home in their later years. They may plan a move in advance to somewhere that they see as more manageable, accessible, cheaper or safer, so that, as their health and needs change they will be prepared and able to cope. But for others a move may be precipitated by a dramatic or sudden event, necessitating a move into alternative accommodation. Decisions about moving or remaining in place are influenced by a range of push and pull factors, summarised by Heywood et al (2002) and shown in the tables below.

**Table 1 Factors encouraging older people to remain in their current housing?**

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<ul style="list-style-type: none"> <li>• Desire to remain independent</li> <li>• Deep attachment to home and garden</li> <li>• Sense of achievement in the home</li> <li>• Memories associated with the home</li> <li>• Fear or dislike of change and the unknown</li> <li>• Liking more space than others consider necessary</li> <li>• Cost of moving</li> </ul>	<ul style="list-style-type: none"> <li>• Retaining status</li> <li>• Sense of security within familiar home</li> <li>• Comfort in a place tailored to suit</li> <li>• Home owned outright</li> <li>• Attachment to furniture</li> <li>• Lack of energy to move</li> <li>• Desire to keep the possibility of family visits</li> </ul>
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**Table 2 Factors encouraging older people to move**

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<ul style="list-style-type: none"><li>• Housework Problematic</li><li>• Maintenance problems</li><li>• Cold and Damp</li><li>• Too far from family</li><li>• Problems with stairs</li><li>• Loneliness, after bereavement</li><li>• No longer being able to drive</li><li>• Neighbour nuisance</li></ul>	<ul style="list-style-type: none"><li>• Garden Problematic</li><li>• Disrepair</li><li>• High costs</li><li>• Inaccessible baths</li><li>• Crime or fear of crime</li><li>• Anxiety about ability to cope in case of accident or illness</li><li>• Not wishing to become a burden on friends or relatives</li></ul>
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**Table 3 Factors attracting older people to move to alternative accommodation**

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<ul style="list-style-type: none"><li>• No garden (or garden maintained by someone else)</li><li>• More company</li><li>• Nearer to relatives</li><li>• Less risk from crime</li><li>• Smaller and more manageable</li><li>• Pleasant views and surroundings</li><li>• Designed for comfort (heating, bathroom, power sockets, windows)</li><li>• Care guaranteed, so no further move ever necessary</li></ul>	<ul style="list-style-type: none"><li>• Good access to shops, doctors and other services</li><li>• No stairs</li><li>• Lower running costs</li><li>• Clean and peaceful</li><li>• Support available in case of emergency</li><li>• No maintenance required or assistance provided</li><li>• Equity release from sale of larger home</li></ul>
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Later sections of this report will highlight the operation of these factors, which illustrate both options and constraints for older people in their housing choices and what might influence their choices about whether to stay in their family home or move to alternative accommodation. In order to maintain their quality of life, older people also need housing that matches their financial resources, maximises their involvement in the community, and meets personal or care needs. In common with younger people, space is an important consideration in housing choice. Rather than moving to or seeking smaller houses, older people may require rooms for visitors or carers, and space to accommodate wheelchairs and walking frames.

## **The relationship between housing and health**

As already mentioned, housing conditions influence both the physical and psychological wellbeing of the occupants. The way in which housing relates to health must be part of this analysis, because inadequate living conditions have been found to lead to increased stress levels, social isolation, poor health and a higher risk of disease and injury (Podger 1998). Numerous factors are involved in the relationships between housing and health, from the structure and maintenance of the building and its location to elements in the lifestyle of the resident, such as income levels and size of household (Howden-Chapman and Wilson 2000). These factors led Howden-Chapman et al (1999) to claim that a gradient in health exists and that people who occupy higher socio-economic status, with higher education, and living in socially advantaged neighbourhoods have better health and longer life expectancy than those in poorer socio-economic conditions (see also the National Health Committee 1998). They argue that this reflects the level of control people perceive they have over their lives. In providing the resident with a degree of control over their accommodation options, home ownership may enhance their wellbeing and positively influence their health status.

### **Physical health**

The most common housing-related health issues are dampness and cold (Howden-Chapman and Wilson 2000). A house that is damp is more difficult to heat, which in turn makes it more susceptible to damp. Cold air increases the risk of condensation, which leads to the growth of mould and mildew and their associated spores (Collins 1993). Dampness in a home is often associated with poor maintenance and insufficient repairs as well as with socio-economic disadvantage (Environmental Epidemiology Unit 1999). Studies have shown links between self-reported and objectively measured dampness in homes and high rates of respiratory illness and asthma amongst older people (McCarthy et al 1985). As dampness levels increase, there is a corresponding increase in the likelihood of the occupants becoming ill, with older people and young children particularly vulnerable (Collins 1986 cited in Howden-Chapman et al 1999).

Older people are less able to judge temperature and adjust to changes than are younger people. Often older people do not heat their homes adequately, leaving them at greater risk of respiratory illness and hypothermic conditions (Anderson et al 1996), and they may experience greater extremes in temperature before they are aware that they need to adjust their heating (Taylor et al 1995). Damp and cold homes appear to be a factor in high winter

mortality due to respiratory disease, heart disease and stroke in older people in Britain (Wilkinson et al 2001, Clinch et al 2000). New Zealand has very high rates of respiratory morbidity, asthmatic conditions and respiratory infectious diseases as well as a high frequency of damp buildings (Howden-Chapman et al 1999).

Despite its relatively temperate climate, New Zealand has a greater seasonal mortality in older people than other countries with more extreme climates (Isaacs et al 1993, Howden-Chapman and Wilson 2000). This may be because older people do not judge temperature correctly, do not dress appropriately for the cold or do not heat their homes adequately. Evans et al (2000) report that people who cannot keep their homes warm in winter are more likely to suffer poor health, and are higher users of health services. They found that the ability to keep the home warm was more important than dampness. The Eurowinter Group (1997) looked at winter mortality in eight European countries and found a link between mortality and lack of home heating, independent of out-door cold stress. A New Zealand study (Frost et al 1992) investigating cardiovascular deaths in Auckland during 1984 and 1985, found that cold was the most influential climate factor associated with increased deaths.

These studies emphasize the importance of adequate heating, insulation and ventilation in housing for older people.

## **Accidents**

Housing design and lack of maintenance can affect injury rates in young children and older people (Howden-Chapman and Wilson 2000). The vast majority of accidents and injuries to those over 65 years occur in and around the house, related to the greater time that older people spend in their home environment (Ministry of Health 1999). In New Zealand, 61% of injuries reported by men aged 65-74 and 78% reported by women occurred in and around the home.<sup>1</sup> The comparable figures for people aged 75 plus are 78% of men's injuries and 82% of women's happening in and around the home. This finding is supported by the international literature. The *Health Survey for England 2001* found that the most common location for major accidents involving people 65 plus was either in the home or garden (Bajekal et al 2003).

ACC Injury Statistics (2002) show that older women lodge greater numbers of claims than older men. This may be related to higher proportions of older women living alone (see

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<sup>1</sup> Around the home means both inside and outside of the home and includes the garage and gardens.

Chapter 2). While the number of claims levelled off for men and dropped for women in the 2002 year, the cost for both groups has risen recently (Cornwall and Davey 2003). Thus, in relation to accidents as well as health, the physical design of homes, the need to make repairs and to maintain the property (which may be an issue especially for older renters), become important issues.

## **Social/psychological wellbeing**

Housing quality is also linked to psychological health and wellbeing. While an association between dampness and respiratory illness has been reviewed, a study also reported that dampness problems in the home are associated with poorer mental health, after controlling for intervening variables such as chronic illness and low income (Hopton and Hunt, 1996a and 1996b). This suggests that older people who are socially isolated and vulnerable, and who are also living in homes that are damp and cold, may have poorer psychological wellbeing than those who are able to afford better accommodation.

Home modification and maintenance also influences psychological wellbeing and decisions about ageing in place. In an Australian study, older people reported feeling more secure and happy and coped better with their daily activities if their home was well maintained (Faulkner et al 2002). The same study showed that being able to modify or make repairs to their home contributed to the wellbeing of older people and their ability to remain in their homes. Data from the *British Household Panel Survey 1990-1992* analysed by Weich and Lewis (1998) indicated that people living in rented accommodation and having two or more minor or any major structural housing problems had a higher likelihood of suffering common mental disorders, after potential confounders had been controlled for. A Netherlands study found that people living independently have better self-image than those institutionalised (OECD 2003, p56).

This links to the issue of social exclusion, which is important, given concerns about older women, low-income renters and Maori and Pacific people. Research indicates that older individuals living in deprived areas are disproportionately likely to experience social isolation and loneliness, compared to those living in more economically favoured areas (Scharf et al Kingston 2002). Howden-Chapman et al (1999) argue that the effects of housing quality should be examined at both the community and individual levels. This is because older people spend more time in their local neighbourhoods as they age. A British study of people over 60 years living in 'deprived neighbourhoods' found that a significant minority of older

people were socially isolated and/or severely lonely, and many older people in these areas were also excluded from community social relationships. Women, those aged over 75 years, those who lived alone and some older people from ethnic minorities, in particular, had a heightened deprivation risk (Scharf et al 2002).

## **Housing tenure and health**

The literature clearly indicates a relationship between housing tenure and both physical health and mental wellbeing. This is not necessarily a causal relationship, as housing tenure may be an intervening variable between income, housing location, condition of the home, and health (Waters 2001). People living in rental accommodation have higher death rates than owner-occupiers (Filakti and Fox 1995, Macintyre et al 1998, Macintyre et al 2001). Scottish research found that people in rental accommodation have higher rates of cardiovascular disease and all-cause mortality than owner-occupiers, even after adjustment for other socio-economic variables (Sundquist and Johansson 1997). McIntyre et al (1998) found that, after controlling for potential confounding factors, being an owner-occupier predicted better mental health and respiratory function and fewer longstanding illnesses. Breeze et al (2002) reported that older people in rented accommodation have poorer health scores than older homeowners.

Ellaway and McIntyre (1998) investigated the relationship between housing tenure and the condition of both the home and the neighbourhood, to assess why housing tenure predicts health status. They found that, after controlling for housing stressors, type of home and neighbourhood conditions simultaneously, housing tenure and income were not associated with any of the health measures tested. They concluded that housing tenure predicts health because it also predicts housing conditions. The conclusion is that owner-occupiers are able to afford better homes that are in better condition and better locations, making them less stressful to live in.

The affordability of housing has also been found to have an effect on health. People who spend a higher proportion of their income on rent are less able to afford food and doctor's visits, which can result in deterioration in their health status (Phibbs 1999). In Australia, both financial and non-financial housing problems are related to housing tenure. The data indicates that people who rent are more likely to face housing difficulties than owners. Housing risks for renters, including overcrowding and living in homes that require urgent or essential repairs, are in turn associated with poorer health outcomes and reduced wellbeing (Waters 2001).

Howden-Chapman et al (1999) argue that, given the link between housing tenure and health, older people in rental accommodation are likely to have higher mortality rates than owner-occupiers. It may also be the case that renters have less ability to control their housing situations and to achieve 'a secure sense of home – that is crucial to wellbeing' (Howden-Chapman and Wilson 2000). A recent study investigating inequalities in the quality of life of people 8,000 people aged 75 plus in Great Britain found that older individuals in rented accommodation had a much higher chance of poor outcomes on quality of life variables (home management, body care and movement indicators) compared with owner-occupiers in the same area, after gender, age and marital status were accounted for (Breeze et al 2002).

A longitudinal survey of older people in Australia also reported that an individual's wellbeing varies with housing tenure. Older individuals who owned their homes or who rented privately fared better than older people who rented in the public housing market (Faulkner et al 2002). Related to this was the older person's access to financial resources, with more affluent older people having better wellbeing scores. In all, the study indicated that older people with few assets, and, in particular, those who had not owned their home by the age of 70 were more likely to have lower wellbeing scores than older owner occupiers.

In the New Zealand context, the *Living Standards of Older New Zealanders Survey* (Fergusson et al 2001, p43) found that people with high accommodation costs were disadvantaged in their material wellbeing scale, compared to those paying low costs. The primary source of housing costs came from rental payments. Among the 'risk' factors for material disadvantage was the paying of rent or mortgage. High levels of renting among older Maori and Pacific people makes these groups more susceptible to lower living standards.

The length of time in the rental or social sector housing is also a factor in the wellbeing of older renters. Breeze et al (2002) found that older people who had lived in social sector housing for most of their adult life had about twice the chance of experiencing poor quality of life outcomes than did people who had been owner-occupiers during their lifetimes. Moreover, older people who had moved from owner-occupied homes into the social housing sector were also more likely to have poor body care and movement scores, as well as poor social interaction and morale outcomes, than people who had remained as owner-occupiers.

## Care and support services

While the housing environment impacts significantly on health and wellbeing, another key factor is the provision of and access to support and care services. Many older people with support needs could manage to live in mainstream housing if it was available, affordable, in good repair and if the necessary support services were provided, regardless of accommodation type (Tinker et al 1999). Accepting, in line with 'ageing in place' policies, that it is ideal for older people to maintain their independence for as long as possible, many of the older-old are likely to require some personal care and support. Only 15% of New Zealanders over the age of 85 remain living in the community independent of services (Ministry of Health 2002). Familial support and help from neighbours are important, but if low-income older people are to remain living in their own homes they may require financial assistance to purchase home-based support services (Senior Citizens Unit 1999). Low-level support services, such as cleaning, gardening, assistance with laundry tasks and home maintenance, play an important role in maintaining the ability to remain independent (NZ Government 2002). The New Zealand *Living Standards of Older People Survey* showed that the activities which cause the greatest difficulties to very old people, because of their health status, are heavy housework, mowing lawns and gardening (Davey and Gee 2002).

The literature shows that 'ageing in place' can only be sustained if housing and support services are integrated and operate well together (Heywood et al 2002). In the UK, some progress has been made to integrate social service and housing investment funds and develop health initiatives (Fletcher et al 1999, cited in Heywood). However, a 1998 report by the Audit Commission in England found that many people were not receiving the assistance they required because of poor collaboration between housing, health and social services (Arblaster et al 1996, Tinker et al 1999).

The link between housing and health, in the widest sense, must be central in the development of housing policy and the design of appropriate accommodation for older people, especially vulnerable groups. This conclusion offers a challenge to 'ageing in place' policies.

## Lifecycle model of housing options

The housing situation of older people cannot be seen in isolation from their experiences and situations in the lifetime leading up to retirement and old age. The conventional New Zealand lifecycle model of housing types is a *career-type* progression up a *ladder* comprising various rungs representing different housing options. This begins with leaving the parental home,

moves into rental accommodation in shared flatting arrangements, progresses to first-home purchase and subsequently trading-up options, which depend on changes in family situation and/or employment location. Thereafter people may *trade down* as children leave home and/or retirement nears. The later stage of this *career* may include a *cashing-up* of the housing asset to pay for retirement-associated expenditure (eg. holidays, health needs, entry into a retirement village). Traditionally, the desire to ‘leave assets for the children’ operates as a brake on the running down of assets.

There are several reasons why people may move, trade down and/or cash up on retirement or the onset of older age:

- to improve access and proximity to health services.
- to retain social interaction through proximity to family as well as other older people.
- the unsuitability - in terms of size or quality - of existing housing for old age and retirement needs or lifestyle.

The first two reasons suggest a shift towards a bigger urban centre or a more accessible location. The third reason suggests the need for maintenance or adaptation expenditures to meet needs.

This stylised model is (arguably) breaking down as changes in family formation and dissolution, in family size, changing lifestyles, as well as employment instability feature more prominently in people’s experience. And, although portrayed as linear, the progression up and down this ladder can, in practice, take various routes as family and employment situations change, including shifts between renting and ownership. However, there is abundant evidence that the model is operating, in a general sense. Most New Zealanders achieve home ownership and retain it until the end of life, whereupon the asset is passed to their heirs. Three-quarters of people aged 65 plus, and more than half of those 85 plus are homeowners. There are, however, groups of older people who have different housing patterns and either do not achieve homeownership or achieve levels of home equity which do not assist them in cashing-up.

In terms of accommodation options for older people a key element underlying the *ladder* analogy of the lifecycle model is the implicit importance and desirability of home ownership. In the context of this study, these observations suggest two groups of special concern.

- People who never achieve home ownership. As a consequence, this group are excluded from the trading down and/or cashing-up options at the onset of older age. Of those who do not achieve home ownership, the majority rent their accommodation.
- People who successfully reach the home ownership rung of the *ladder* but are limited in their cashing-up options because the saleable value of their home is insufficient in comparison to the current price of alternative accommodation options. This group are likely to have difficulties if they wish to move in later life. They may be excluded from certain accommodation options. For example, people moving from smaller to larger centres may be disadvantaged through differences in house prices. If they cannot afford to move they may be left in an unsuitable location but in a house which is too big and/or requires too much maintenance to sustain their desired standard of living.

## Relevance for future

If the stylised lifecycle model is breaking down, what is its relevance in looking to the future? Arguably, it is still relevant to the near future, but its significance will decrease with time, as future uncertainties increase. Several questions still arise -

- How will perceptions and expectations concerning inheritance change? If people become less concerned about leaving assets for their children, will this open up the possibility of using home equity for other purposes (see below)?
- Will people be led to disinvest or ‘cash-up’ before retirement, to improve consumption and living standards?
- Will student debt and general indebtedness reduce accommodation options and progress towards homeownership?
- How will the housing market change? If the ageing trend is not coupled with economic, wealth, income and migration growth amongst the younger population then the ability of oncoming cohorts to cash-up may be curtailed.
- Do recent reductions in home ownership rates reflect a preference shift (towards rental accommodation) or a delay in the entry onto the housing market, as younger people explore other options (e.g. travel, consumer spending)? In either case, a change in home

ownership patterns will affect the options available to tomorrow's older population.

This preliminary review of housing issues points to important considerations that policy makers in New Zealand need to examine when they consider how best to meet the housing needs of older New Zealanders. Appropriate, well-maintained and affordable housing stock needs to be available so that older people have a range of preferred living and support arrangements. However, if affordable and appropriate housing is not available to older people then this is likely to negatively impact on an older person's health and wellbeing and their ability to 'age in place'.

## Chapter 2. The Present

This chapter is arranged in three sections. The first presents factual data on the characteristics of older New Zealanders relevant to their housing needs and options. It provides a background to the second section, which is a discussion of current housing options. The third section is an economic analysis of the present situation, laying out the costs and benefits from individual and government perspectives. An examination of the present situation is an essential starting point in looking to the future. Information on trends and characteristics from this chapter will be referred to in subsequent analysis.

### Part 1: Characteristics of older New Zealanders

#### *New Zealand's population is ageing*

Ageing is defined as growth in the proportion of the population 65 years and over. In 1951, when total population was 1.94 million, 9% (177,000 people) were in this age group. In 2001 the proportion had risen to 12% (450,426 people) out of a total of 3.7 million.

#### *The older population is itself ageing*

Within the older population, it is the age group 85 years and over which has the highest growth rates. This group quadrupled from 5% of the population 65 and over (9,534 people) in 1956 to 9% (38,463 people) in 1996 (Khawaja 2000). It is important to differentiate within the population aged 65 and over. Frequently a 'young-old' group is defined, from 65 up to 75 or 80, who tend to be healthy, active and involved in a variety of activities. The 'old-old', from age 80 or 85, are more likely to suffer from health problems and disability.

#### *Life expectancy is increasing*

International data show large increases in life expectancy (LE) both at birth and at the age of 65, and that life expectancy is consistently greater for females than males (Jacobzone 2000). These trends apply to New Zealand, where, in 1999-2001, LE at birth was 76 years for males and 81 years for females (Statistics New Zealand 2001) (Table 4). This has been increasing and, during the 1955-2001 period, grew by 7.8 years for males and 7.9 years for females.

**Table 4 Life expectancy (years) at selected ages, by gender 1999-2001**

Age	Life Expectancy		Gender Difference
	Male	Female	Female-Male
0	76.0	80.9	4.9
1	75.5	80.3	4.8
15	61.7	66.5	4.8
45	33.5	37.5	4.0
65	16.5	19.8	3.3
85	5.3	6.5	1.2

Source: Statistics New Zealand (2001)

When considering population ageing, it is important to focus on LE at the ages of 65 and 85. Between 1970 and 1999/2001, both male and female LE at age 65 increased significantly. For women it increased from 15.9 to 19.8 years and for men from 12.6 to 16.5 years. At age 85, over the same period, LE increased by more than one year for both males and females. The relative increase at 85 years was greater than at age 65.

**Table 5 Life expectancy (years) and independent life expectancy (years) at age 65**

	Total	Male	Female	Maori Male	Maori Female	Pacific Male	Pacific Female
Life expectancy at birth	77.8	75.2	80.4	68.0	72.3	69.8	75.6
Life expectancy at age 65	17.8	16.1	19.5	12.6	15.0	13.4	16.6
Independent* life expectancy at age 65	10.9	9.9	11.9	7.4	7.5	NA	NA

\* Implies free of disability requiring assistance

Source: Statistics New Zealand, New Zealand Life Tables, and Ministry of Health 2001

At age 65, women, on average will live three and a half years longer than men (Table 5). They can also expect a longer period of independence, but, because of their longer lives, they also have, on average, more years with a disability requiring assistance (7.6 years compared to 6.2 years for men). Table 5 also illustrates ethnic differences in LE rates. Maori LE at birth is 7-8 years lower than non-Maori for both males and females, but the gap is reduced to four years at age 65.

### *Women outnumber men among older people*

Women outnumber men by a significant margin among older people in New Zealand and the gap widens as age increases – a pattern repeated in most countries of the world (Kinsella and Velkoff 2001). This is largely because women have lower mortality rates and longer life expectancy. The gender balance is about 50/50 up to age 70, but beyond this females outnumber males by a significant amount. In 2001, 70% of people aged 85 and over were women and the proportion rose to 80% for those aged 95 or more.

### *The older age groups are fairly homogenous by ethnicity*

The 65 plus population is much more predominantly Pakeha (European descent) than the New Zealand population as a whole. Pakeha account for 80% of the population as a whole, but 92% of people aged 65 plus. Proportions in other ethnic groups decrease with age, as shown in Table 6. These patterns derive from lower LE in non-Pakeha groups. As a result, numbers of Maori and Pacific people are very low in the oldest age groups. The 2001 Census figures show that there were under 700 Maori aged 85 and over, 300 Pacific people and just over 400 people of Asian affiliation (figures are affected by rounding). Together, these three groups represent only 4 % of people in the 85 plus age group.

**Table 6 Age groups 65 plus (in private dwellings) - ethnicity**

	Maori %	Pacific people %	Asian %	European %	Other %	Not specified %	Total %
65-74	5.3	2.1	2.9	85.2	0.2	4.4	100
75-84	2.5	1.2	1.5	89.8	0.1	4.9	100
85 plus	1.7	0.8	1.2	90.5	0.2	5.6	100

Source: *From Birth to Death* database for 2001<sup>2</sup>

### *Marital/partnership status varies by age and gender*

Using legal marital status categories, the proportions of both men and women who are married decrease with age, while the proportion widowed increases. These trends are much more pronounced for women, who have traditionally married men older than themselves and

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<sup>2</sup> The *From Birth to Death* databases derive from social monitoring begun in the 1980s through the New Zealand Planning Council and continued at Victoria University by Judith Davey. The subject population for the databases is population in private dwellings on census night who usually live in these dwellings. The total New Zealand usually resident population at the 2001 Census was 3,737,277. The *From Birth to Death* database covers 93% of this population. This database has adopted a consistent sole-ethnic-group definition since 1981.

then outlive them. In the 85 plus age group, three-quarters of the women are widowed and only one in every ten is married. Men are much more evenly divided between the married and widowed categories.

Social marital status – whether an individual is partnered or not – rather than legal marital status is the variable of interest in terms of living arrangements. The proportion of older people who are partnered is higher than those who are legally married, suggesting that some are living in de facto or same-sex partnerships. For example, in the age group 85 plus, 50% of men are partnered but 44% are legally married. For women the corresponding figures are 11% and 9% (Table 4).

**Table 7 Social marital status – percentage partnered, age groups 65 plus**

	<b>65-74</b>	<b>75-84</b>	<b>85 plus</b>
Male	79	72	50
Female	59	34	11
Total	69	50	24

Source: Statistics New Zealand, 2001 Census, National Summary Table 19

*Older people generally live in small households*

Marital or partnership status has a strong influence on household composition. Within the older age groups household composition varies by age and gender. Overall, around 80% of people 65 and over either live alone or with a spouse/partner only. The proportion of people living alone increases with age from 24% of those aged 65-74 to 41% of the 75-84 age group and 56% of people 85 plus, and is higher for women. At age 85 plus, a third of men and two-thirds of women live alone. This proportion has been growing steadily over recent decades and applies in all ethnic groups (Table 8). Men aged 85 and over are almost five times as likely to be living in a couple-only household than women of that age. Couple-only households have also been growing, according to recent census results.

**Table 8 Age group 85 and over, usual household composition by gender and ethnicity, 1981-2001**

	Couple only/couple with children %	One- parent %	Multiple family %	Non family %	One- person %	Not classified %	Total %
<b>Male</b>							
Pakeha	51	3	6	2	38	0	100
Maori	27	13	25	5	27	3	100
Pacific	24	7	46	4	15	4	100
Asian	30	4	49	4	11	2	100
<b>Female</b>							
Pakeha	12	8	7	3	70	0	100
Maori	9	17	26	5	41	2	100
Pacific	4	7	61	7	18	3	100
Asian	4	10	56	2	24	4	100

Source: From Birth to Death databases.

Other household types are much less important for older people. The *From Birth to Death* databases show that multiple family and non-family households have been declining in importance. Nevertheless, multi-family households are the third most common household type for older men and women. Living with ‘children’ of whatever age is not a common living arrangement for older people.

Multi-family households are a much more common living arrangement in non-Pakeha ethnic groups (Table 9). In the 75 plus age group, 60 % of Pacific people live in such households and over 20% of Maori. Many of the overall patterns by gender are repeated in each ethnic group – a higher proportion of women living alone and a higher proportion of men in couple-only households.

**Table 9 Age group 75 and over, usual household composition by ethnicity, 1981-2001**

	Couple only/couple with children %	One- parent %	Multiple family %	Non-family %	One- person %	Total %
<b>Maori</b>						
1981	25	8	32	8	27	100
1986	27	12	26	4	31	100
1991	25	14	22	4	35	100
1996	27	11	22	4	36	100
2001	26	11	22	4	36	100
<b>Pacific</b>						
1981	12	4	62	7	15	100
1986	12	8	64	4	12	100
1991	15	7	65	2	11	100
1996	15	5	63	3	14	100
2001	16	6	61	4	12	100
<b>Pakeha/Other</b>						
1981	37	4	10	8	41	100
1986	41	5	6	4	44	100
1991	41	5	5	3	46	100
1996	42	4	5	3	46	100
2001	43	4	5	2	45	100

Source: *From Birth to Death* databases.

Differences in household composition have important implications for the care and security of very old people as well as for housing needs.

### *Health status is a measure of wellbeing*

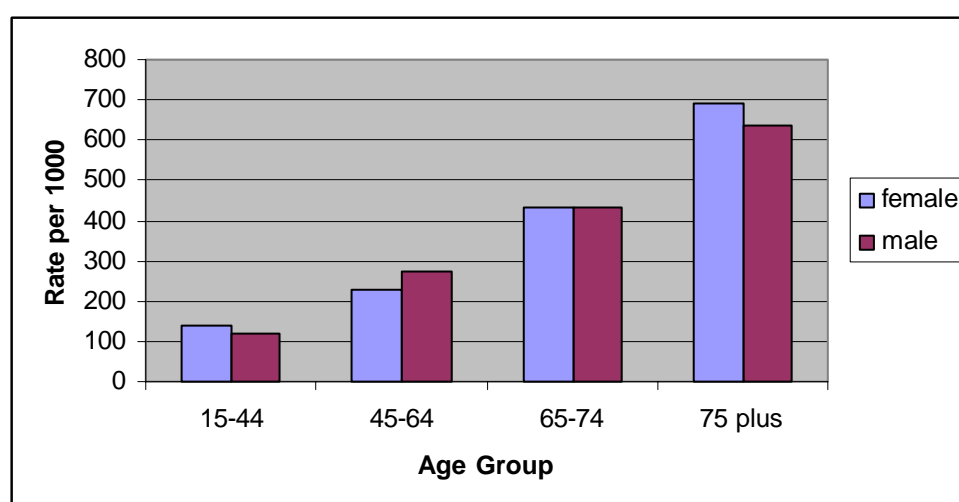
Self-assessed health status reflects wellbeing in later life. As people age, there is a decline in self-assessed health status. Fewer rate their health as 'excellent' or 'very good' and more think it is only 'fair' or 'poor' (Table 10). However, even in the 85 plus age group, 26% rate their health as excellent or very good - rather more women than men.

**Table 10 Self assessed health status, by gender and age**

	65-74		75-84		85+	
	Male %	Female %	Male %	Female %	Male %	Female %
Excellent	18	17	12	15	12	8
Very good	32	32	28	26	12	20
Good	30	31	26	29	35	35
Fair	15	17	27	22	32	23
Poor	5	4	8	8	9	16
	100	100	100	100	100	100

Source: *Living Standards Survey* consent database.

**Figure 1 Prevalence of disability, by age and gender: 2001**



Source: *Statistics New Zealand* 2001 Household Disability Survey and 2001 Disability Survey of Residential Facilities

### *Disability rates increase with age*

According to the 2001 Disability Survey, the likelihood of having a disability<sup>3</sup> increases with advancing age. In the 75 plus age group 69% of women and 64% of men reported some level of disability (Figure 1). The vast majority of older adults with disabilities remain living in the community. Four percent of adults with disabilities live in residential care facilities and 92% of these are over the age of 65. The severity of disability also increases with age. Around 36% of people aged 75 and over had a moderate disability (requiring some assistance or special equipment, but less than daily) and 18% had a severe disability (requiring daily assistance), according to the 2001 survey. For people aged 65 and over, living in the

<sup>3</sup> Survey respondents were defined as having a disability through questions about activity limitation. The person may or may not require assistance for the disability.

community, the most common types of disability relate to mobility, agility, deafness and visual impairment.

The rate of disability in older Maori is higher for both males and females than the overall figure (Table 11). For Pacific people, males have a lower prevalence of disability compared to total and females are only slightly above.

**Table 11 Prevalence of disability, older New Zealanders by ethnicity, 2001, rate per 1000**

	Maori	Pacific	Total
Male	540	460	512
Female	670	580	558

*Incomes are generally low among older people*

At the 2001 Census, the median annual income for a person 65 and over was \$13,120 (around \$252 per week before tax), compared with a median income for all adults of \$18,550. Older men had higher median incomes than older women - \$13,610 and \$12,800 respectively. Median incomes for Maori and Pacific people, total and aged 65 plus, were lower, being lowest for Pacific people (Table 12).

Differences in income by gender persist beyond retirement from paid work. Males continue to predominate in the higher incomes levels, even at 85 plus and this applies in all ethnic groups (Table 13). In the older age range Pakeha men are the most likely to have incomes over \$20,000, followed by Maori men.

**Table 12 Median annual incomes for people 65 plus and all adults by gender and ethnicity, 2001**

Gender	Age	Total \$ p.a.	Maori \$ p.a.	Pacific \$ p.a.
Males	65 and over	13,610	11,780	9,760
	15 and over	24,910	18,580	17,750
Females	65 and over	12,800	11,580	9,990
	15 and over	14,530	13,220	12,970
Total	65 and over	13,120	11,670	9,880
	15 and over	18,550	14,830	14,790

Note: Ethnicity data based on all ethnic affiliations recorded

Source: Statistics New Zealand 2001 Census

**Table 13 Age groups 65 plus, percentage with personal incomes \$20,000 and over, by gender and ethnicity, 2001**

		Maori	Pacific people	Pakeha
<b>Male</b>	65-69	18	10	32
	70-74	9	5	24
	75-79	11	4	23
	80-84	16	4	16
	85 plus	8	9	21
<b>Female</b>	65-69	10	6	17
	70-74	6	4	14
	75-79	13	6	13
	80-84	13	4	13
	85 plus	5	4	12

Source: *From Birth to Death* 2001 database

The personal incomes of older people are generally low and, because most of them live in one or two-person households, and the same is generally true of their aggregate household incomes. The exceptions illustrate the link between household composition and household income. Older Maori and Pacific people are more likely to live in households in the top two quintiles of household income, because many, especially older Pacific people, live in multiple family households. In 2001, 32% of Pacific people and 29% of Asians aged 75 and over lived in households in the top two quintiles, as opposed to 11% of Maori and 8% of older Pakeha people (*From Birth to Death* 2001 database). The later discussion of housing tenure by income, defines three levels of household income.

#### *Older people have income from a variety of sources*

All who meet the residential requirements are eligible for New Zealand Superannuation at age 65. The majority do not rely on this source entirely. According to year 2000 data, 80% of couples over 65 and 70% of single people received additional income from other sources, although the dollar value of this may be low (Statistics New Zealand 2004). The *Living Standards of Older New Zealanders* Survey provides comprehensive information on income sources (Table 14). Men are much more likely than women to have income from salaries and self-employment, to have private superannuation and investment income. There are also

differences by ethnicity. More Pakeha have investment income and private superannuation than older people from other ethnic groups.

Apart from New Zealand Superannuation (NZS) or Veterans' Pensions, the main welfare benefits received by older people are the Disability Allowance (DA) and related allowances (including residential care subsidies), which increase in importance by age and the Accommodation Supplement (AS). Further information on the fiscal impacts of these payments is included in the third section of this chapter. Difference by gender and ethnicity in both size and sources of income help to explain differences in housing circumstances and housing needs.

**Table 14 Sources of income (% in age group)**

Sources of income	65-74	75-84	85+
<i>Private sources of income</i>			
Interest from banks, finance companies	76	79	77
Dividends, unit trusts	36	23	19
Private pension	18	21	15
Family trust	4	4	4
Rents	7	4	3
Overseas income	3	2	1
Self employment	9	2	1
Maori / leased land	1	1	
Honoraria	2	0.5	
Business partnership	1		
Royalties	1		
<i>Private sources of income</i>			
NZS/veterans pension	98	99	97
Community services card	69	78	74
Disability allowance	11	16	21
Other government allowance	6	10	14
Other government pension	5	6	5
Accommodation allowance	5	4	5
War disability allowance	4	10	4

Source: *Living Standards of Older New Zealanders Survey*, consent database  
(blank cell indicate less than 0.5%)

*Most older people have low levels of savings and investments*

The *Living Standards of Older New Zealanders* (Fergusson et al 2001) estimated the value of savings and investments (excluding own home) for people 65 and over. The results showed that 56% of single respondents had savings and assets of less than \$10,000 and 72% had savings of less than \$25,000. Couples generally had higher levels of saving and investments, but 36% still had joint assets of less than \$10,000 and 51% had assets of less than \$25,000.

**Table 15 Estimated total value of savings and investments (excl own home)**

Value (\$000)	Single (n=1407) %	Partnered (n=1224) %
<1	30.6	20.9
1–10	25.3	15.4
10–25	15.9	14.7
25–50	9.0	12.3
50–100	7.3	9.7
100–200	5.6	10.1
200–300	2.7	5.5
300–400	1.6	4.3
400+	2.1	7.0
Median value of investments	\$7,500	\$37,500

Note: All values in the table were estimated from the observed sample weighted to take account of probability of selection, non-response and sample stratification.

Source: Fergusson et al 2001

This section has illustrated the importance of ageing as a major feature of New Zealand’s population. Social trends, in terms of partnering and household circumstances also influence housing needs and choices, as do patterns of income and asset accumulation. The information also clearly shows differences by gender and ethnicity, especially with respect to life expectancy, living arrangements, income levels and sources.

## Housing situation of older New Zealanders

### *Most older people live in private dwellings*

According to the 2001 Census, there were over 407,000 people aged 65 and over - 91% of the total - resident in private dwellings. The remaining 38,800 lived in non-private dwellings, such as rest homes, boarding houses, motels, etc. The proportion in non-private dwellings increases with age, but does not exceed 5% until past the age of 80. Of 48,650 people aged 85 and over, 31% (15,200 people) were in non-private dwellings. This compares with a proportion closer to 10% for the 65-plus group as a whole.

### *Few older people live in residential care, but the proportion increases with age*

In 2001, 12,500 people aged 85 and over were residential care, 80% of them women. This represents 19% of men and 31% of women in this age group. Between 1996 and 2001 the number of older people in residential care increased by 20%, but growth was concentrated in the 85 plus age group. Small numbers make ethnic breakdowns unreliable, but it is clear that very few non-Pakeha are in residential care. In all ethnic groups the proportions of females in residential care are higher than for males. The residential care population is ageing and people are at higher levels of disability when they enter rest homes. This means that more very old people, even with significant disabilities, remain living in the community.

### *Multi-unit dwellings are a significant housing type for the very old*

Table 16 illustrates dwelling type by the age of the oldest adult in the household. The proportion who live in multi-unit dwellings (defined as flats/units/townhouses/ apartments /houses joined together, or part of a business or shop) increases with age. Pensioner housing and some retirement village units will fall into this category ('other' includes holiday homes, caravans and temporary dwellings).

**Table 16 Dwelling type by age of oldest adult**

	Private dwelling (not specified) %	Separate house %	Multi-unit dwelling %	Other %	Total %
65-74	8	74	18	1	100
75-84	12	64	24	0	100
85 plus	14	57	29	0	100

Source: *From Birth to Death* 2001 database.

*The proportion living in smaller dwellings increases with age*

About half of older people live in average size dwellings of 5-6 rooms (Table 17). The proportion in small dwellings, with under 5 rooms, increases with age. Over 90% of people 85 and over who are living alone are in small or medium dwellings.

**Table 17 Number of rooms in private dwellings, by age of oldest adult**

	Under 5 %	5 or 6 %	More than 6 %	Total %
65-74	17	47	31	100
75-84	23	50	22	100
85 plus	29	46	18	100

Source: *From Birth to Death* 2001 database.

**Table 18 Age groups 65 plus, tenure patterns, 2001**

Age group	Owned with mortgage %	Owned without mortgage %	Owned unspecified %	Rented %	Rent free %	Not Specified %	Total %
65-74	9	68	1	12	4	6	100
75-84	5	69	2	13	4	7	100
85 plus	5	64	3	15	5	9	100
Total population	39	25	1	29	3	4	100

Source: *From Birth to Death* database 2001

*Mortgage-free ownership is high among older people, but varies by ethnicity*

In 2001, three quarters of New Zealanders aged 65 or over, usually resident in the community, lived in owner-occupied housing. Older people are much more likely to own their homes without a mortgage than the general population and less likely to rent, although the renting proportion increases slightly with age from 65 onwards (Table 18). Ownership without a mortgage is the leading type of housing tenure for all ethnic groups, except for Pacific people. At age 75 plus 55% of Pacific people are in rented accommodation, compared to 31% of

Maori and 16% of Pakeha people.

Housing tenure trends over the 1981 to 2001 period, by ethnicity, are available from the *From Birth to Death* databases for the 75 plus age group, and shown in Table 19. Over the last ten years there has been a decline in home ownership among Maori and Pacific people, but this is not evident for the Pakeha/Other group. Seventy-five percent of Maori aged 75 and over lived in owned accommodation in 1981 and 69% in 2001. The decrease was even more dramatic for Pacific people, with ownership falling from 62% to 45%.

**Table 19 Age group 75 plus, housing tenure by ethnicity, 1981-2001**

	Owned with mortgage %	Owned without mortgage %	Rented or rent free %	Total %
<b>Maori</b>				
1981	18	57	25	100
1986	14	57	29	100
1991	16	52	32	100
1996	14	54	32	100
2001	11	57	31	100
<b>Pacific</b>				
1981	31	31	38	100
1986	33	25	42	100
1991	34	22	44	100
1996	26	26	48	100
2001	23	23	55	100
<b>Pakeha/Other</b>				
1981	9	72	19	100
1986	7	76	17	100
1991	6	77	17	100
1996	9	73	18	100
2001	5	79	16	100

Source: From Birth to Death databases.

The *Living Standards of Older New Zealanders* Survey includes a wider range of tenure types than the census (Table 20). This also shows an increase in renting by age, especially from

local authorities. A considerable proportion of people 85 and over live in homes owned by family members. Family trust ownership is more common for the 65-84 age group than for older people, but will probably increase in significance in the future.

**Table 20 Home ownership by age of respondent**

	65-74	75-84	85+
	%	%	%
A family trust	6	8	3
Self or partner (with or without mortgage)	81	78	67
Family members	4	5	16
Private landlord not related to me	3	1	2
Local authority	2	2	6
Housing NZ	3	4	3
Other	1	2	4
	100	100	100

Source: Living Standards of Older New Zealanders, consent database

*Older renters have a variety of landlords*

Of the 43,000 people aged 65 and over who rented their accommodation in 2001, over a third rented from private landlords and just under a third from Housing New Zealand (HNZ) or other central government agencies, especially territorial local authorities (TLA) (Table 21).

**Table 21 Category of landlord for renters aged 65 plus by gender and ethnicity**

	Private person or business	HNZ or other public sector	TLA	Private Trust	Not Specified	Total
	%	%	%	%	%	%
65 plus						
Maori	35	36	16	6	7	100
Pacific people	23	65	7	1	4	100
Asian	65	17	6	4	8	100
Pakeha	37	25	25	8	5	100
Other	62	14	11	2	11	100
Not specified	35	29	20	5	11	100
Total male	41	25	22	7	5	100
Total female	35	31	21	8	5	100
Total	37	29	22	7	5	100

Source: *From Birth to Death* database, 2001

The main gender difference is that older men are more likely to rent privately than older women and the reverse is true for renting from HNZC. This may relate to differences in income. Older Maori and Pacific people are more likely to rent than older Pakeha and Table 21 indicates that a high proportion of older Pacific people rent from HNZC compared to other groups. Comparatively few Pacific or Asian people live in local authority rentals. Small numbers make disaggregation by gender and ethnicity unreliable.

**Table 22 Category of landlord for renters aged 65 plus by age and gender**

	Age group	Private person or business %	HNZ or other public sector %	TLA %	Private Trust %	Not specified %	Total %
Total	65-74	38	29	18	6	9	100
	75-84	27	29	26	8	10	100
	85 plus	24	22	29	11	14	100
Male	65-74	41	24	20	6	9	100
	75-84	30	25	26	9	10	100
	85 plus	27	20	25	12	16	100
Female	65-74	36	32	16	6	10	100
	75-84	25	31	26	8	10	100
	85 plus	22	22	30	11	15	100

Source: *From Birth to Death* database, 2001

Table 22 shows differences in landlord by age of renters. The proportion of people with private landlords decreases with age, as does the proportion with HNZC. The proportions renting from local authorities and from trusts, on the other hand, increase with age. These patterns apply to both men and women.

### *Housing costs vary by tenure and by landlord*

Housing costs collected through the *Living Standards of Older New Zealanders* Survey show the highest figures for HNZC accommodation, although this was before income-related rents were re-introduced (Table 23). People with private landlords had the next highest costs, much higher than for those in TLA housing. Owner-occupiers clearly have much lower costs. In all categories except for family ownership, costs for partnered people were higher than for single

people.

**Table 23 Distribution of home ownership (%) and mean accommodation costs per week (\$w)**

Owner of accommodation	Single (n=1618)		Partnered (n=1442)	
	%	Mean \$pw	%	Mean \$pw
Older person and/or partner	67.9	24.2	86.2	30.1
Family Trust	6.6	6.8	6.0	20.1
Family members	9.3	21.6	2.0	18.6
Private landlord	3.1	115.7	2.6	139.0
Local authority	4.6	65.5	0.6	86.9
Housing New Zealand	4.8	134.2	2.0	141.1
Other	3.7	78.2	0.6	88.8
Total	100		100	

Note: All values in the table were estimated from the observed sample weighted to take account of probability of selection, non-response and sample stratification.

Source: Fergusson et al 2001

## Characteristics of older people by housing tenure

In order to focus on the groups nominated for special attention in this research – renters, low income people, Maori, Pacific people and women – a series of cross-tabulations by housing tenure were carried out for the 65 plus age group, based on 2001 Census data. People living alone have been added to the specified groups.

### *Income patterns vary across housing tenure categories*

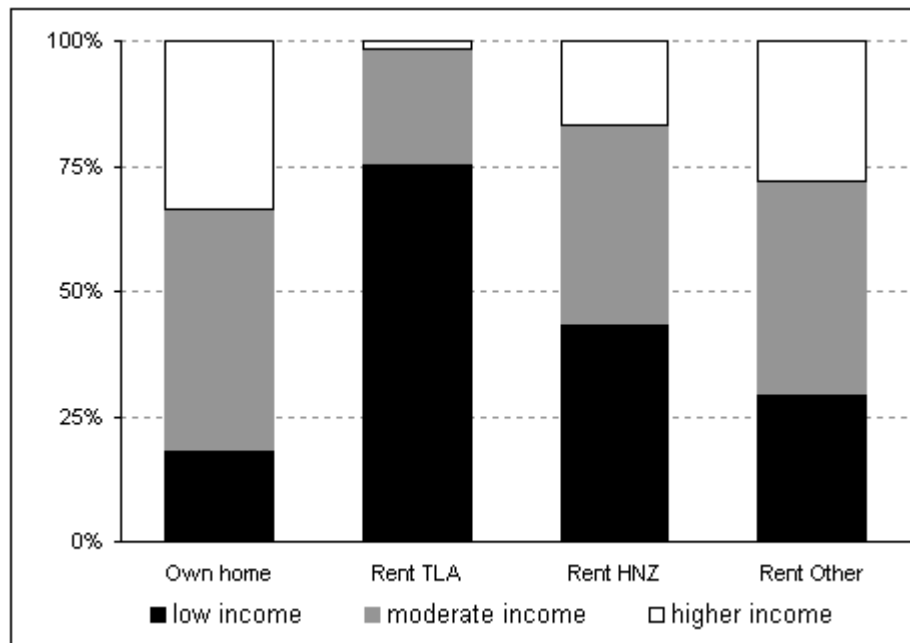
Homeowners differ from renters very clear in their income patterns. Annual household income data has been grouped into three categories.

- low (less than \$15,000)
- moderate (between \$15,000 and \$30,000)
- higher (more than \$30,000).

A high proportion of renters have low household incomes and this applies in absolute terms

(as a proportion of each rental group) and in relative terms (in comparison to the proportions in the homeowners group).<sup>4</sup> This is very clear for territorial local authority (TLA) and Housing New Zealand Corporation (HNZC) tenants, of which 75% and 43%, respectively, fall into the low-income category, as opposed to 29% of people with private landlords and only 18% of homeowners (Figure 2).

**Figure 2 Composition of housing tenure categories by income**



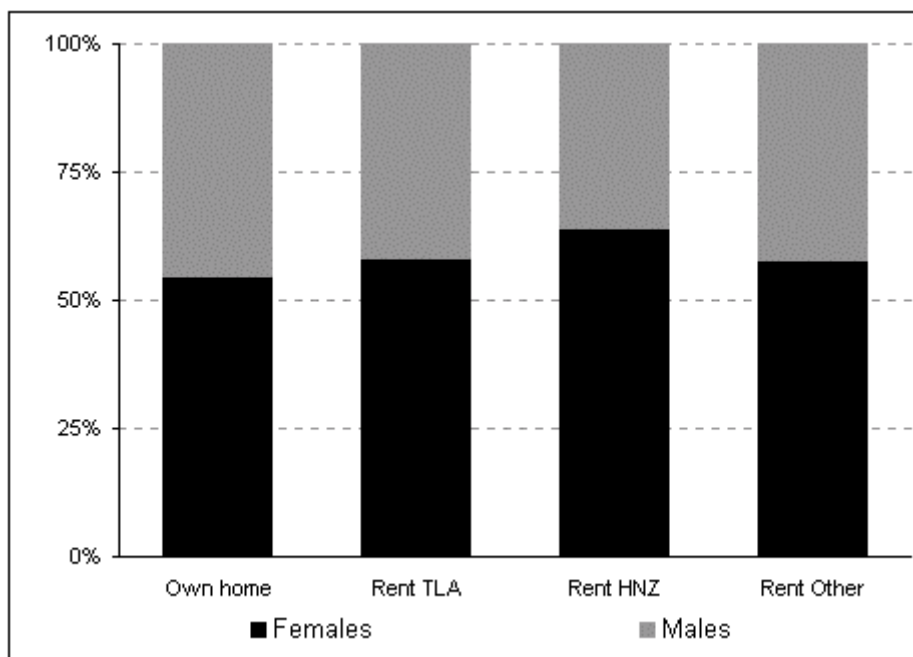
However, this 18% still represents over 49,100 people, equal to the total number (across all income categories) renting from private landlords, more than five times the number renting from TLAs, and more than four times the number of HNZC tenants.

*There are gender differences in housing tenure*

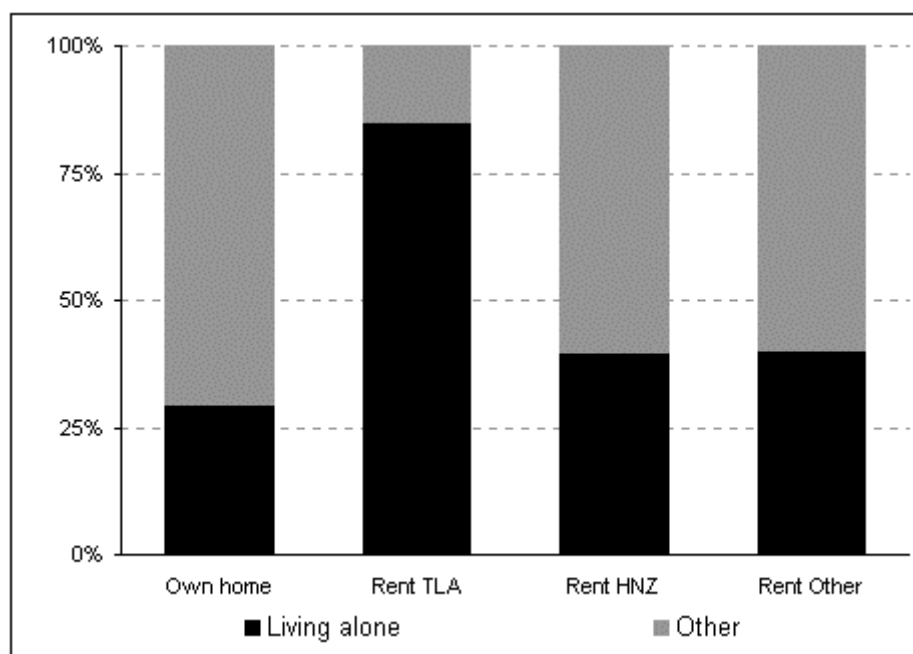
Women make up 54% of those aged 65 and over who are homeowners, 57% of those renting from private landlords, 58% of TLA and 64% of HNZC tenants.

<sup>4</sup> Note that there is also an ‘income not stated’ category which - in the absence of additional information - is assumed to be distributed pro-rata across the three income categories.

**Figure 3 Composition of housing tenure categories by gender**



**Figure 4 Composition of housing tenure categories by those living alone**



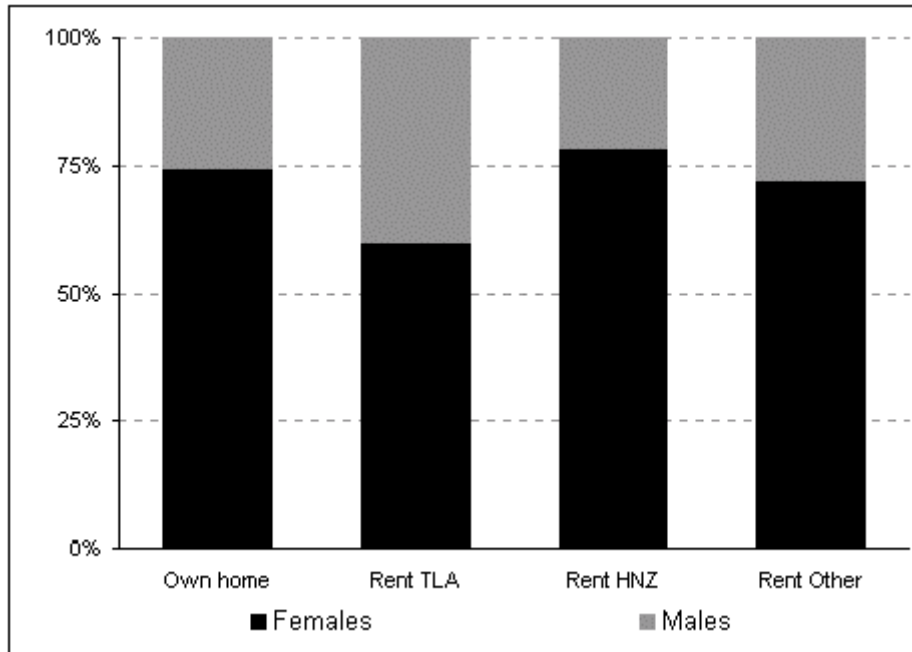
*Living alone, differences by tenure and gender*

A very high proportion (close to 85%) of TLA tenants live alone, as shown in Figure 4. This comprises nearly 7,900 of the 9,300 people over 65 who live in TLA rentals. In other tenure

categories the proportion living alone is well under half. However, in numerical terms, the largest groups of older people living alone are homeowners - nearly 90,000 people in 2001.

As already noted, a high proportion of people over the age of 65 who live alone are women. This is true for all tenure types except TLA housing (Figure 5).

**Figure 5 Those living alone, by tenure and gender**



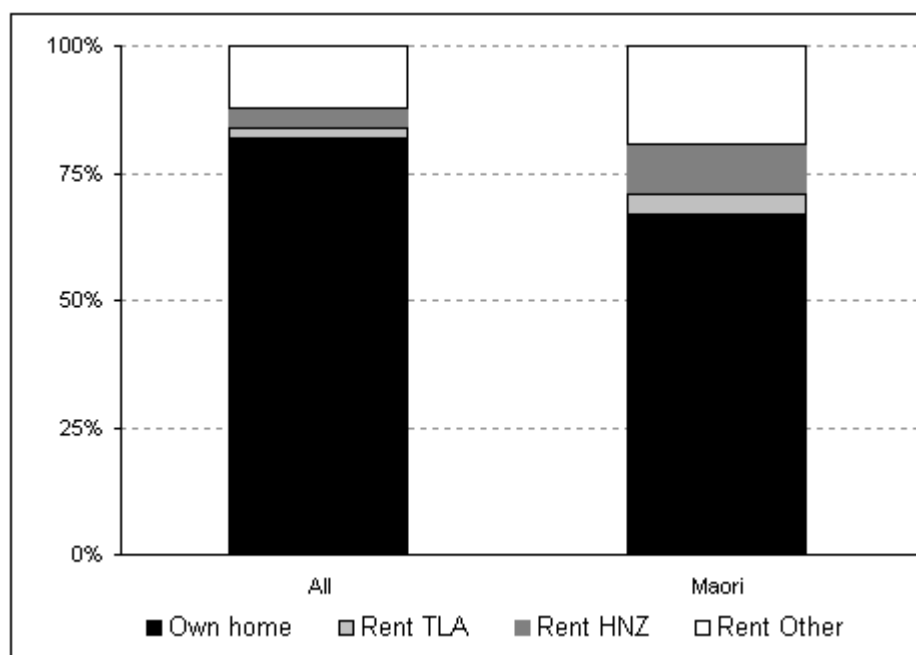
In summary, a higher percentage of renters than owners come into the low household income category, but numerically there are more low income older people living in houses which are owned than which are rented. The overall gender balance is similar across the tenure categories, but this is not the case for older people living alone. TLA renters are different from the other groups in having very high proportions in the low household income group and also living alone, especially men. This probably reflects the composition of TLA stock, which includes large numbers of bed-sitters and very small units.

## Housing situation of older Maori

This section builds on information presented earlier on the characteristics of older Maori by giving further breakdowns by tenure. It is worth restating that the numbers of Maori in these sub-categories are very small, especially in the older age groups, and caution must be exercised in interpretation.

Overall, there were nearly 16,000 Maori aged 65 and over resident in private dwellings, according to the 2001 Census, with a further 860 in non-private dwellings. The number of Maori in residential care (414 of the 860) is a very small proportion of the overall residential care total of 24,600 people. Sixty-seven percent of Maori 65 and over are homeowners compared with 81% of total population in this age group. Nearly 3,000 older Maori rent from private landlords, while 1,400 rent from the HNZC and another 650 are TLA tenants (Figure 6).<sup>5</sup>

**Figure 6 Tenure, Maori and total, 65 plus, in private dwellings**



In many ways the patterns for older Maori reflect those of the total population aged 65 and over. There are higher proportions of older Maori women living alone, compared to older Maori men, in all tenure categories. Tenure by income distribution for older Maori is also similar to that for the total population (compare Figure 7 below with Figure 2 on page 50).

<sup>5</sup> A further 930 are in the not elsewhere classified (NEC) category.

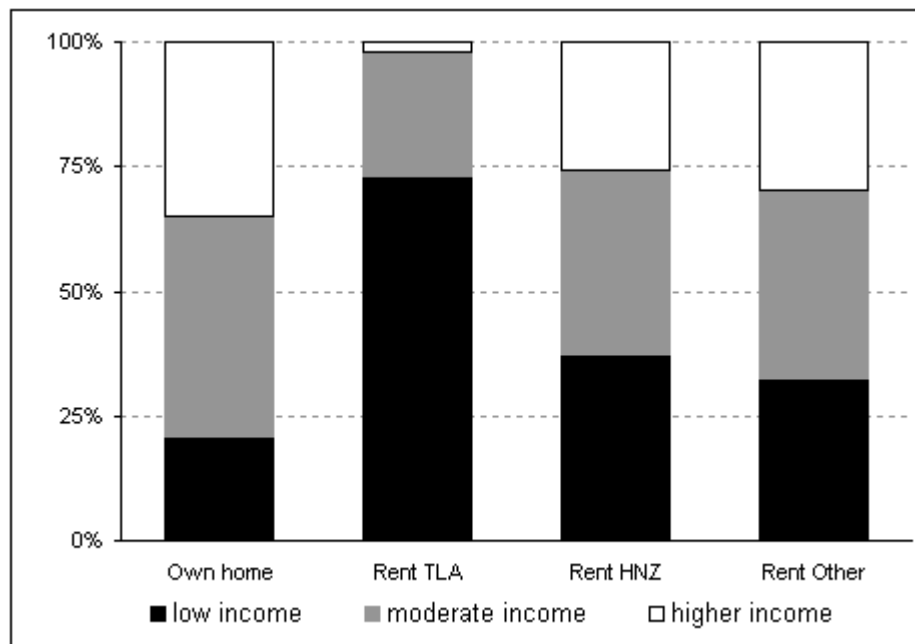
Bear in mind that this is household income and Maori households are on average larger. Again, it is TLA tenants who are the most likely to fall into the low-income category. Further, the overwhelming majority of older Maori who rent from TLAs are living alone (540 out of a total of 650) (compare Figure 4 on page 51). The proportions living alone are lower in other tenure categories.

Ten thousand Maori aged 65 and over reside in their own homes. Disaggregation by income for this group is difficult, as nearly a quarter did not state their income levels in the 2001 census. Leaving this aside, Maori homeowners have a similar income breakdown to the total 65 plus population, as shown in Figure 7.

- 44% of older Maori homeowners have low incomes (less than \$15,000)
- 20% have modest incomes (between \$15, 000 and \$30,000)
- just over 33% higher incomes (more than \$30,000).

As expected, most of those in the low-income bracket are living alone. In terms of actual numbers, 1,550 Maori home owners aged 65 plus reported an annual household income of less than \$15,000 and 1,270 of this group are living alone.

**Figure 7 Composition of Maori housing tenure by income**



## Housing situation of older Pacific people

This section adds to information on older Pacific people presented earlier in this chapter. The 2001 Census showed very low totals for Pacific people aged 65 and over and so cautions mentioned in relation to Maori figures must be reiterated here.

**Figure 8 Tenure, Pacific people and total, 65 plus, in private dwellings**

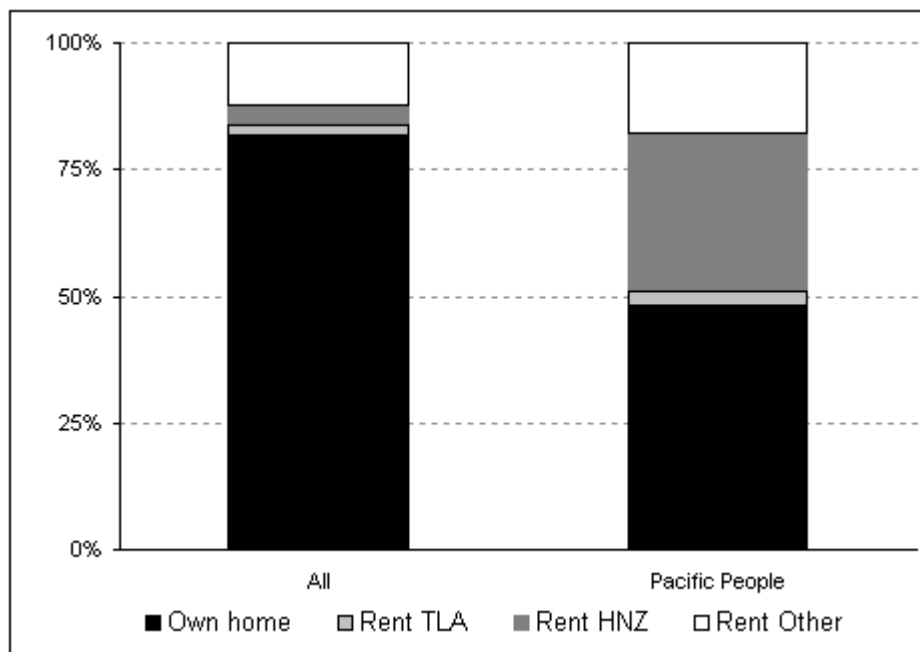
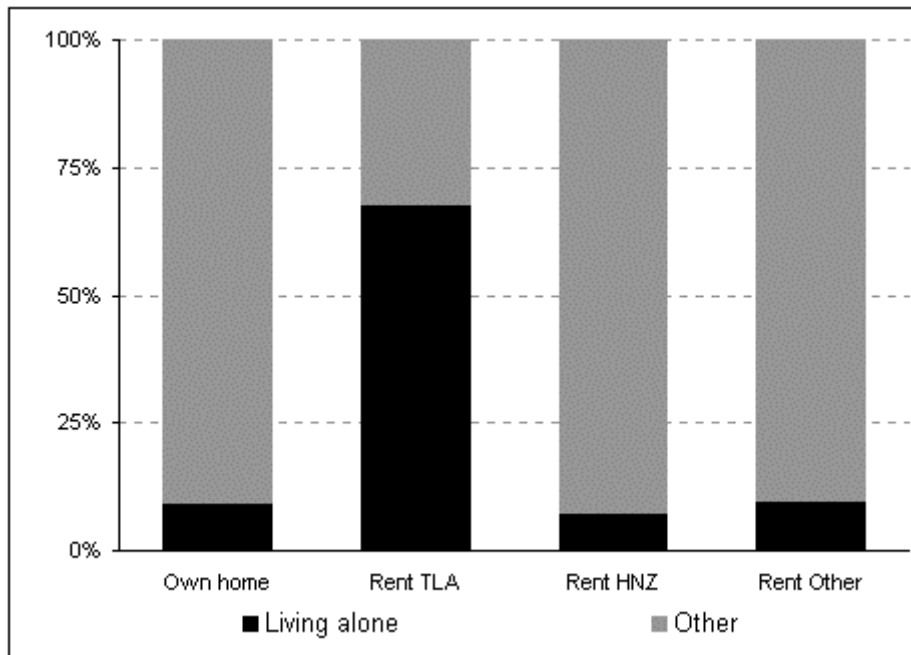


Figure 8 shows that, compared to the total 65 plus population, older Pacific people have much lower homeownership rates and the proportion of HNZC tenants is significantly higher. In terms of numbers, out of a total of 6,830 older Pacific people in private dwellings in 2001 nearly 3,100 were homeowners and over 2,000 rented from HNZC. Only 204 rented from local authorities and 1,170 from other landlords. The 2,000 older Pacific people renting from HNZC represent roughly 16% of all HNZC tenants aged 65 and over.

Figure 9 shows that a relatively small proportion of the Pacific people aged 65+ live alone, except for TLA tenants.

**Figure 9 Composition of Pacific people housing tenure categories by those living alone**



A large ‘not stated’ category in the 2001 Census makes it impossible to compare income levels in this group with any meaning. Small numbers also prevent disaggregation for Pacific people in the 85 plus age group. In 2001 there were only 246 Pacific people aged 85 and over in private dwellings and a further 66 in non-private dwellings.

The main differences in tenure patterns between older Maori and Pacific people and the total population 65 and over are in the proportions of homeowners, linking to ethnic differences outlined in earlier sections. Older Maori and Pacific people are less likely to live alone in all tenure types. However they are similar in patterns of tenure by gender and they share the rather different characteristics of TLA tenants as against other groups of renters.

Detailed cross-tabulations are included in Appendix 3.

## Part 2: Current housing options for older people

The statistical information presented in Part 1 provides details of tenure patterns and a limited amount of information on housing type and size. At present the majority of people aged 65 and over live in homes which they own and which are similar to ‘mainstream’ housing. But there are other options, including types of rental and supported accommodation, up to rest home level. Part 2 describes these options and some of the current issues surrounding them.

### Homeownership

#### *Housing condition, maintenance, adaptation and renovation*

The *Living Standards of Older New Zealanders* study questioned participants about problems with their accommodation. Fewer than 10% of the 65 plus group were currently experiencing every type of problem specified, apart from noise. Problems with exterior paintwork, dampness, plumbing, interior paint and roofs followed (Table 24). For the oldest group, plumbing was the most important problem after noise.

**Table 24 Problems with current accommodation – percentage of occupiers experiencing problem by age**

	65-74 years	75-84 years	85 plus	Population as a whole
Noise	10.2	9.2	6.0	21
Exterior paint	7.0	6.1	3.7	19
Dampness	4.9	3.8	2.6	19
Plumbing	4.8	3.8	4.2	11
Interior paint	4.5	3.7	1.4	18
Roof	3.9	2.7	0.3	12
Pollution	3.2	2.8	3.2	7
Draughts	3.1	3.4	2.9	21
Windows	3.1	2.4	2.4	15
Fences	2.4	2.2	1.4	15
Paving	2.1	1.5	0.7	10
Doors	2.0	1.2	1.5	10
Wiring	1.2	0.3	0.8	6
Piles	1.0	0.3	0.2	5

Source: Living Standards of Older New Zealanders Survey, consent database.

While a small proportion reported suffering from dampness and draughts, which are linked to

health problems (Chapter 1), the data do not suggest that older New Zealanders have major concerns about housing fabric.

Surveys of house conditions, carried out for the Building Research Association of New Zealand (BRANZ) in 1994 and 1999, also indicated that most New Zealanders are satisfied with the condition of their houses. This is despite the conclusion that the housing stock is not being sufficiently maintained, and that there are significant gaps between 'required and intended expenditure' on household maintenance (Clark et al 2000). While the reports show that older homeowners spend less on home maintenance than their younger counterparts, sample sizes are too small to give a meaningful analysis of the actual maintenance needs of older homeowners.

Lack of assistance with home maintenance, adaptation and renovation may precipitate loss of independence for older people. Housing may not be suitable for people with disabilities or because deteriorating quality is affecting health. Some home maintenance services, aimed at older people, are provided through organisations (Age Concern, Grey Power). Assistance (financial and information) with house adaptations is available through health authorities under DSS (Vote:Health), although asset testing is likely to exclude many homeowners. The ACC can assist with adaptations, but only where the need is related to accidental injury and not age-related incapacity. Advances on NZ Superannuation are available for essential repairs, but the maximum sum is very low and the money must be repaid.

Enable New Zealand assists people with disabilities (lasting for six months or more) by providing access to information, funding for equipment and housing alterations, needs assessment and service coordination ([www.enable.co.nz](http://www.enable.co.nz)). Enable manages funding on a contractual basis from the Ministry of Health and ACC. Assistance for modifications costing over \$7,900 requires an income and asset test through Work and Income New Zealand. Enable can assist with grants towards housing modifications which allow disabled people to be mobile in and around their homes, or to return to or remain in their homes. Specialist assessments are made by occupational therapists.

Renovations and large maintenance tasks (repainting, reproofing, re-wiring) are big-ticket items, which may be hard to fund out of superannuation or savings and home ownership may exclude many older people, if asset-testing is applied.

### *Rates and ongoing housing costs*

Local authority rates and property insurance premiums have been rising in recent years and can cause financial stress. There is anecdotal evidence that increased rates are encouraging older people to move away from high-rates areas. Some assistance is available through local authority rates rebates, but the amounts available and eligibility criteria mean that take-up is very low. The Rates Rebate Scheme was established through the Rates Rebate Act 1973. Ratepayers who apply to their local council for a rebate are assessed according to their income and number of dependants. The majority of rebate recipients are welfare beneficiaries. Funding is reimbursed to councils through the Department of Internal Affairs and the maximum rebate is \$200. Numbers of recipients have fallen in recent years because the scheme's income limit has not kept pace with increases in New Zealand Superannuation. The Department of Internal Affairs is currently undertaking a review of the rates rebate scheme.

### *Opportunities to trade down*

Owners have the option to trade down to more appropriate housing - a smaller house or pensioner flat - but often there is still a financial gap and it may be difficult to find somewhere well located, low maintenance, close to services and activities.

### *Making use of home equity*

Homeownership and income patterns mean that many older homeowners are 'house rich, income poor'. They may be living on low incomes, which they have little opportunity to augment once they leave paid work, but at the same time have considerable assets tied up in their houses. If older people express a strong desire to remain in their present homes, this points to the possibility of mobilising their housing wealth through some form of equity release. Home equity is already among the personal assets being called upon to pay for long-term residential care, although the exemption levels are being progressively raised. Examples of home equity release schemes are discussed in Chapter 3, see pages 85.

## **Rental accommodation**

New Zealand's rental housing stock consists of both private and state sector rentals and the characteristics of renters have been described earlier in this chapter.

### *Issues for older renters in the private sector*

The largest group of older renters have private landlords. Renting provides less security of tenure and anecdotal reports suggest that rental accommodation is of a lower standard than privately owned homes. However, there is no reliable evidence to this effect. Detailed results from the 1992/93 Housing New Zealand survey of the public rental housing stock were never published (DTZ New Zealand 2004). While the need for adaptation, renovation and maintenance work is the same as for homeowners, renters have less autonomy and there may be a trade off between improvements and rent levels. Older people do not want to see their rents go up so accept lower standards and their health may suffer.

### *Housing New Zealand Corporation (HNZC) rentals*

HNZC is the largest provider of public rental housing accommodation for citizens who are in housing need, including older people. In 2001, 8,163 households where the oldest member was 65 or older rented from HNZC. This represented 16% of HNZC tenant households. The profile of older tenants by ethnicity is 63% Pakeha, 17% Maori, 17% Pacific people, and 3% Asian. Maori and Pacific people are therefore over-represented in this group.

Many HNZC rental properties were built during the period of state housing expansion following World War II. Nearly 60% were constructed before 1970. There has been minimal expenditure on modernisation over the 1990s, but HNZC is now in the process of upgrading or updating its portfolio. A significant portion of this housing has outdated amenities and is not well matched to the needs of households today. Nearly 50% is three-bedroom houses. Demand from older people is for one and two bedroom units. With a changing tenant mix and an ageing population, HNZC will review the type of houses it acquires and update obsolete or run down stock to reflect these changes.

The HNZC states, in its submission to the research, that:

...[the] ability to meet the needs of older people in housing is constrained by competing priorities. However, the government is committed to increasing the supply of affordable state rentals and significant modernisation programmes to raise the amenity value of the state portfolio to modern standards. HNZC Case Managers assist with the process of adapting homes, public and private, and finding suitable or adaptable homes to meet the needs of people with physical disabilities. The Corporation is refining its working practices with the disability sector and disabled people to ensure a seamless

delivery of housing modifications. To aid this work a new Statement of Intent measure is in place to ensure HNZC utilises its modified or potentially modifiable properties.

Key features of the HNZC Action Plan linking housing policy to older people's needs include:

- ensuring that well-insulated modern homes are available to older tenants
- partnerships with community groups, voluntary associations and iwi bodies to maintain social housing, including that for older people
- initiatives to address sub-standard rural dwellings, including those containing households with older people facing health or disability problems
- providing income related rents to older state housing tenants on low incomes and ensuring that older people get access to state housing on the basis of need.

The HNZC Development Guide incorporates 'universal design' features, allowing the construction of properties that are suitable for a wide range of tenants. 'Universal design' is the principle that ensures that housing is designed to be suitable for people with disabilities. Lifetime Homes, a concept incorporating universal design principles, is discussed in Chapter 3, page 79.

Local Government Housing Fund and the Housing Innovation Fund, administered through HNZC, is a four-year allocation of \$43.3 million in capital funding and \$19.8 million in operating funding. This aims to encourage greater involvement in housing by local government and third sector organisations. This funding will be in the form of interest-free suspensory loans for up to half of new unit costs, these loans repayable if the housing is sold. Funding is also available for up to half of modernisation and reconfiguration costs, with a cap of \$30,000 per unit. As of mid-2004, loans from the Housing Innovation Funds, to develop housing for older people were confirmed or under negotiation with the Palmerston North Lutheran Homes Trust Board, the Thames Pension Housing Trust, Abbeyfield Hamilton, the Fowler Trust Lumsden, and Presbyterian Support Central.

#### *Territorial Local Authority (TLA) housing*

Local government is the second largest provider of social housing in New Zealand after HNZC. Most local authorities offer rental accommodation to low-income people, applying eligibility criteria related to age, income and assets. This stock has been developed in the past

using government assistance in the form of low interest loans and grants. McKinlay Douglas found that fewer older people have sought TLA housing recently, and it has been made available instead to younger single adults, often with a history of psychiatric illness or other special needs (2004 p37). The fall in demand may be related more to the type and condition of pensioner units than a fall in numbers of low-income older people requiring housing, but little information is available to explain the trends. The majority of the 14,000 unit local authority stock consists of bed sitters and one bedroom units, which no longer reflect housing preferences of older people (this can be linked to the high proportion of TLA tenants living alone).

Like HNZC, many TLAs now face problems maintaining their ageing housing portfolios and providing stock that better suits changing demographics, including the needs of an ageing population. Deferred maintenance and the costs of upgrading, also threaten the economic viability of TLA stock. There is an emerging need for capital upgrades (to both kitchen/bathroom services and to reconfigure bed sitter units) to bring properties up to acceptable contemporary standards.

At the time of the last comprehensive survey of TLA pensioner housing (carried out by the Department of Internal Affairs in 1996), all local authorities owned some pensioner units. The survey found that, at that time, there were mixed opinions on the future of pensioner housing – some TLAs had recently sold units and some intended to sell, some were reviewing their policies and some were committed to retaining their existing stock. A subsequent study of local authorities and their relationship with older people in their communities revealed that the ‘provision of pensioner housing was no longer ‘universal’ (Gee et al 2000, p22). The number of local authorities who provide housing for older people has fallen since the mid 1990s, as has the number of pensioner units available. However, a survey conducted in July 2003 by HNZC found that 90% of local government (general) social housing stock is held by councils which are committed to housing and only 6% to councils with a decreasing or no commitment (McKinlay Douglas 2004, p6).

Current views therefore continue to be mixed, although, under the Local Government Act 2002, pensioner housing became a council strategic asset. Councils that want to sell will first need to consult with their community. Some councils, who still own and operate pensioner housing, specifically employ liaison officers to support their tenants. As an example, Masterton District Council provides a 24-hour emergency line in all of its units and one of its housing complexes has a live-in custodian.

Examples of local authority pensioner housing and surrounding issues, using information provided by the New Plymouth District Council and the Christchurch City Council can be found in Chapter 3 (pages 97 and 99). The same chapter includes an example of local authority housing sold to a voluntary organisation: - Compassion Homes in Upper Hutt.

### *Voluntary sector housing*

A range of voluntary organisations provide accommodation and residential care for older people, generally aiming at low income people and those with special support needs, but still able to live in the community. Most of the larger landlords are charitable or religious organisations and most of this accommodation is rented. The following examples illustrate current provision, although no comprehensive figures are available for this sector, which is included with private landlords in census figures.

#### **Wellington Masonic Villages Trust**

The Trust has accommodation for older people in Levin, Hutt Valley and Masterton. The first two developments are similar to commercial retirement villages, providing villas (license to occupy), rental flats, a rest home and hospital. They have restaurants (which welcome outsiders), shopping buses, and activities to promote social interaction. The Masterton development has villas and rental flats. Two-bedroom units are preferred and one-bedroom units are harder to sell. The rental flats are popular, especially in Levin, which is a lower socio-economic area.

#### **The Salvation Army**

The Salvation Army offers older people rented independent living units located separately, in 'pensioner villages', or near a rest home. The clusters are all purpose-built and vary in size. Mosgiel has 30-40 units and Nelson 54. Most are one-bedroom units. There are no income and asset tests for eligibility and rents are low, down to around \$70 per week. Most developments have waiting lists. Each area has a referral officer who is either the manager of the rest home or a SA officer to arrange letting and maintenance of units. The rents cover inside and outside maintenance. Where there is a rest home in the development, tenants may purchase meals and laundry services.

#### **Presbyterian Support Services**

Presbyterian Support Services (PSS) cover a range of housing options and care services. PSS

rest homes provide short-term, respite or convalescent care. Some PSS housing for older people takes the form of self-contained cottages and villas located in proximity to rest homes. People renting these live independently but have access to home support services, meals and care from rest home staff, as required. PSS schemes also provide personal care and household assistance to older people with disabilities who to continue living in their own homes. Meals on wheels are also provided to clients who can be either self-referred or referred by a GP or the local NASC (needs assessment) agency.

### **Abbeyfield New Zealand**

Abbeyfield is a volunteer-based, not for profit, organisation that provides affordable quality rental housing on a communal living basis. The houses are aimed at older people, lonely and alone, with low incomes and limited assets, but people who have previously owned a house are not excluded. No capital contribution is required in a community-funded house. An alternative model accepts resident capital contributions, which are repaid on departure in accordance with house revaluation at the time.

An Abbeyfield house can accommodate between 8 and 10 residents, who must be able to care for themselves. Each resident has an ensuite room. Communal areas, furnished by the Abbeyfield Society, comprise a shared kitchen, laundry, dining and sitting room facilities. A guest room is available and residents have access to a garden. Each house has a resident housekeeper who takes responsibility for household shopping, management and care of all communal areas, and the preparation of two main meals per day.

Four houses have been established in New Zealand. Stoke (Nelson), Masterton, and Motueka are community funded rental houses. Whangarei is a resident capital contribution house. Eleven more houses are in development (further information on Abbeyfield is presented in Chapter 3, page 96).

### *Kaumatua flats/Iwi housing schemes*

Many iwi-based and other Maori organisations provide housing for older Maori in the form of kaumatua flats, but currently there is no funding available for new developments. Existing flats were funded through the former Department of Maori Affairs. These were sold to local marae in the mid 1980's, when the department divested itself of its lending portfolio, and the marae continue to manage them (information provided by TPK). These are generally located on or near a marae and provide not only housing for older people, but also a way of keeping

elders connected with their iwi community and extended families. Many of the flats were built as bed-sitter units and there is some criticism that this does not allow relatives/visitors to stay. Being located on or close to marae grounds, the residents often became the de facto providers of marae services, for example welcomes. TPK suggest that the flats were a good solution 15-20 years ago, but they not sure if they are the solution for today or the future.

More recent guidelines developed by HNZC for kaumatua housing specify that these flats need to have two bedrooms so that older Maori people can have family and grandchildren to stay, as well as space to accommodate a live-in caregiver if one is required (Hoskins et al 2002). An example of kaumatua housing, managed by the Te Ati Awa Kaumatua Housing Trust in Waitara, is discussed on p97 of Chapter 3.

### *Housing for older Pacific people*

The Ministry of Pacific Island Affairs' 1999 *Housing Report* has no specific reference to older people's housing. Earlier sections of this chapter show that older Pacific people are over-represented in HNZC housing and that a much higher proportion live in extended family households than is the case for older people from other ethnic groups. Further information is provided in Chapter 5.

### *Residential care*

Numbers of older people living in residential care are quoted earlier in this chapter, and this type of accommodation is not the focus of this report. However, the balance between numbers of older people living in the community and in residential care influences the demand for supported housing. People are entering residential care at higher levels of disability and at older ages than in the past. Under 'ageing in place' policies the rest home concept is being re-thought – although immediate demand and sunk costs mean that rest homes will continue to be provided in the short or medium terms.

### *Retirement villages*

Retirement villages represent a move away from the suburban housing that New Zealanders have traditionally preferred (Leonard 2003). Many private companies are building retirement villages and residential care facilities and they range from small private businesses to large public companies such as MetlifeCare™ and Summerset. Retirement villages have

introduced a market oriented business model alongside the social service model of housing and care for older people provided by religious and welfare organisations and have been linked with commodification of ageing and lifestyle (Simpson 2003).

Features of retirement villages in New Zealand include the following:

- A collection of houses or flats within a defined area that usually offer services such as communal facilities, social activities, security, maintenance and gardening.
- People still effectively live in their own home, although there are a variety of tenure types from freehold ownership, 'license to occupy' and rental arrangements.
- Some retirement villages combine independent units with residential/hospital-level care facilities.
- Because the majority of retirement villages require some form of capital contribution, they are not available to those with low asset or savings levels.
- A weekly service charge usually covers maintenance of grounds and buildings, rates, communal facilities, recreational activities and some transport.
- The Retirement Villages Act 2003 now provides better protection for older people in this type of housing. The Act requires all retirement villages to be registered.

Details of retirement villages on a national basis, are not available.<sup>6</sup> However the *Living Standards of Older New Zealanders* Survey asked whether the respondent was living in a retirement village. The proportion answering 'yes' increased with age, from 5.9% of people 65-74, to 7% of those 75-84 and 12.5% of people 85 and over. Growth in retirement villages was rapid during the 1990s. Leonard (2003) suggests that around 4% of people over the age of 65 now live in retirement villages and Simpson (2003) estimates the population at 23,000. The proportion of the older population living in retirement villages is lower in New Zealand than in Australia or the USA.

In March 2003 the Retirement Villages Association commissioned a survey of its members (Bell et al 2003). At that time there were 153 villages on the association's membership list, housing an estimated 10,200 people. The research was based on responses from 1310 residents. The following highlights from the findings typify retirement villages and their occupants.

- The average age of the residents was 80.
- The average age of moving into the village was 76.

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<sup>6</sup> There is no category of housing in the census which can be identified as retirement villages.

- The residents were two-thirds female and one-third male.
- The villages ranged from under 25 to over 200 units.
- 59% of the residents lived alone.
- 63% lived in two-bedroom units.
- 66% drove a car or lived with someone who did.
- Levels of satisfaction among residents were very high
- People move into retirement villages for the lifestyle, security, more easily managed houses and sections and because help and care services are available on-site.

### *Secondary dwellings*

During the 1980s there was interest in the concept of relocatable housing units, which could be constructed alongside the primary home to provide affordable housing for older people with low incomes and few assets. These were colloquially known as 'granny flats'. The (then) Housing Corporation provided subsidies for 'granny flats' through local authorities. Jowett (2003) suggests that the scheme was not as successful as hoped, with under 250 units being built by 1990. A range of local authorities still allow for and encourage relocatable granny flats in their district schemes (Gee et al 2000).

## **Part 3: Accommodation for older people – current costs and benefits**

The framework for a cost-benefit evaluation of current accommodation options for older people must consider from whose perspective the evaluation is to be undertaken and the options to be evaluated. While individuals face a selection of benefits and costs when evaluating options, there are also additional elements impacting on government and the wider community. In theory the net sum of all these impacts determines the impact on overall wellbeing from a national perspective. Such costs and benefits are usually a combination of financial and economic measures (impacts on income and/or expenditure) as well as *intangible* measures, which include lifestyle, independence, emotional wellbeing and broader quality of life indicators. In practice, it is difficult to quantify many of these benefits and costs.

Cost-benefit assessment is *relative*, meaning that not *all* costs and benefits need to be identified or assessed. The critical elements are those that are expected to differ across the range of options being considered. In other words, the key issue is whether the cost or benefit is related to (or dependent on) the options being evaluated. Many costs and benefits are likely to be similar across the options and need not be considered.

### **Options for home owners**

For older homeowners options include:

- remaining in their own home
- upgrading their home
- ‘trading down’
- moving to a retirement village.

The potential costs and benefits that could differ across these options include direct and indirect financial effects, and less tangible effects, such as (in no particular order) the effects of upheaval, social isolation, independence, mobility, sense of security and wellbeing associated with proximity to relevant services such as health services.

Direct and indirect financial effects can be:

- one-off: such as costs of upgrade, capital availability, removal and other transaction costs
- recurring: such as rates, weekly rental or lease, medical expenses and associated transport costs.

In many ways, the set of effects identified align with the underlying reasons requiring or forcing housing choices in older age, as noted in Chapter 1:

- to improve access and proximity to health services
- to retain social interaction through proximity to family and other older people
- the unsuitability - in terms of size or quality - of existing housing for later life needs or lifestyle. For example, the house may be too big and/or requires too much maintenance to retain a desired standard of living.

Common to many of these elements is the link between health and housing. As Chapter 1 has pointed out, there are health benefits associated with living in homes appropriate to individual needs, consistent with the goal of ageing in place.

**Table 25 Options facing homeowners from the individual's perspective**

<b>Option</b>	<b>Benefits</b>	<b>Costs</b>
Remaining in own home	Independence Future options retained as capital asset remained intact	Maintenance Social isolation Distance from health services
Upgrading own home	Independence Improved health and mobility	Upgrading costs and on-going maintenance Social isolation Distance from health services
Trading down	Reduced maintenance costs Proximity to health services and other amenities Improved health / mobility Free-up capital for other spending	Removal and other transactions costs Social upheaval and/or isolation
Retirement Village / Social Village / shared accommodation	Social interaction Proximity to health services/other amenities (and) ready access to continuum of care Sense of security	Capital entry cost Weekly rental/licence payment

Figures from Statistics New Zealand's *Household Economic Survey* (Statistics New Zealand 2001) indicate that spending on health services and property maintenance are significant components in the household budgets of older people, along with fuel and power. All these costs are influenced by the physical nature of the property. The *New Zealand House Condition Survey* (Clark et al 2000) conducted for BRANZ concluded that an average of \$4,000 per house was required to repair the more serious defects. The average maintenance expenditure by the surveyed homeowners (in the order of \$1,500) was insufficient to maintain the housing stock in a satisfactory condition. The average expenditure is similar to the numbers listed in Table 26 although the *Household Economic Survey* includes homeowners of all ages.

**Table 26 Indicative housing-related costs for an average older persons' household**

<b>Household Type</b>	<b>% of total expenditure</b>	<b>Total annual \$ (2002/03)</b>
<b>Primary income source is NZ Superannuation</b>		
Health Services	4.1	732
Domestic fuel and power	5.3	960
Property maintenance goods	2.2	398
Property maintenance services	3.9	700
<b>'Reference person' is 65 or over</b>		
Health services	4.2	949
Domestic fuel and power	4.5	1,018
Property maintenance goods	2.2	493
Property maintenance services	5.8	1,305

Source: Statistics New Zealand 2001.

The potential benefits and costs from the government's perspective are primarily associated with impacts on health and Accommodation Supplement expenditure. These are shown in Table 27 below.

**Table 27 Options facing homeowners from the government’s perspective**

<b>Option</b>	<b>Benefits</b>	<b>Costs</b>
Remaining in own home	Reduced requirements for assistance for accommodation costs	Provision of disability and other health services direct to home or to wider region
Upgrading own home	Reduced requirements for health and disability related services - but still required direct to home or to wider region	Assistance to upgrade homes of low income persons
Trading down	Reduced requirements for health and disability related services - but still required direct to home or to wider region	
Retirement Village (or similar) arrangement	Reduced requirements for health and disability related services Lower unit costs of disability services provision	Assistance with capital and weekly payments for those that meet qualifying criteria

### **Options for renters**

From an individual’s perspective the two options are private or public sector landlords. There are considerations of location, such as proximity to health services and other amenities; availability; and impacts on social interaction and independence. In addition, security of tenure is a significant factor for tenants in the private sector. On the financial side, the on-going rental cost is the key difference.

From the perspective of government, the key distinctions lie in whether -

- public sector accommodation is (or can be) situated in the vicinity of the health services and other amenities
- there is a requirement to significantly modify/upgrade public housing stock to make it more appropriate for older people
- there are on-going maintenance and administration costs for public sector housing and the quantum of capital tied up in the ownership of such housing.

Table 28 and Table 29, below outline tenants’ options from the individual and the government

perspective.

**Table 28 Options facing tenants from the individual's perspective**

<b>Option</b>	<b>Benefits</b>	<b>Costs</b>
Renting from a TLA or HNZN	Social interaction / independence / mobility  Proximity to health services / other amenities (and) ready access to continuum of care if situated appropriately  Lower rent than private sector	Proximity to health services and transport costs if situated away from centre
Renting from private landlord	Proximity to health services and other amenities situated appropriately	Rent higher than public sector  Insecurity of tenure

**Table 29 Options facing tenants from the government's perspective**

<b>Option</b>	<b>Benefits</b>	<b>Costs</b>
Renting from a TLA or the HNZN	Reduced requirements for health and disability related services if situated appropriately	Assistance with accommodation supplement for those that meet qualifying criteria  Maintenance and upgrading (and/or establishment) costs to ensure quality accommodation leading to improved health outcomes
Renting from private landlord	No maintenance or upgrading costs  Capital not tied up, released for other government requirements	Assistance with accommodation supplement for those that meet qualifying criteria

### **The broader options**

Where there is an *a priori* argument that costs and/or benefits are associated with a particular accommodation option or options, then policy measures can be justified to ensure an improvement in the overall net benefit. In essence, the government costs and benefits set out in the tables above provide the basis for a public good argument for government action. This should aim to shift the benefits and costs from the individual's perspective to one that improves overall wellbeing. The previously discussed link between health status and housing

tenure provides the basis for such an argument. Studies that control for income, age, gender and ethnicity still find a positive relationship between health status and housing tenure, in favour of homeownership. This suggests another reason for encouraging ownership.

In this context, the options need to be viewed more broadly than just between owning and renting. The relevant options can be expanded to:

- home ownership
- renting from the public sector
- renting from the private sector
- retirement village or similar arrangement
- social village/shared accommodation
- residential care.

Table 30, below, sets out the broader options from both the government and the community perspective.

It may be argued that private sector rental accommodation is of an inferior standard to owner-occupied and public sector housing. For this to be true, requires an explanation for a lack of incentives for landlords to maintain the standard of their property. In the theoretical world of the perfect market, the landlord would clearly wish to maintain a quality product in order to reap maximum on-going rental income as well as potential capital gain. However, the real world property market is inherently imperfect with asymmetric<sup>7</sup> availability of information.

As noted in Chapter 1, renters have few options open to them, given a lack of capital, while homeowners with low levels of equity may be limited in their options. In this light, improved acquisition and dissemination of information on property standards (whether owned or rental) would improve the workings of the property market and, correspondingly, overall wellbeing.

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<sup>7</sup> That is, one side (usually the seller) knowing more about the product for sale than the other side (usually the buyer).

**Table 30 The broader options, from the government and community perspectives**

<b>Option</b>	<b>Benefits</b>	<b>Costs</b>
Home ownership	<p>Reduced requirements for health and disability related services</p> <p>Reduced requirements for assistance for accommodation costs</p>	<p>Assistance to upgrade homes of low income persons</p>
Public sector renting	<p>Reduced requirements for health and disability related services where situated appropriately</p>	<p>Assistance with accommodation supplement for those that meet qualifying criteria</p> <p>Upgrading (and/or establishment) costs to ensure quality leading to improved health outcomes</p> <p>On-going maintenance</p>
Private sector renting		<p>Assistance with accommodation supplement for those that meet qualifying criteria</p>
Retirement village (or similar) arrangement	<p>Reduced requirements for health and disability related services</p> <p>Lower unit costs of disability services provision</p>	<p>Assistance with capital and weekly payments for those that meet qualifying criteria</p> <p>Costs associated with accommodation</p> <p>Establishment (land + building) costs if sited close to urban centres</p> <p>Social isolation if sited on periphery of urban areas</p>
Social village / shared accommodation and other amenities	<p>Reduced requirements for health and disability related services</p>	<p>Establishment (land + building) cost</p> <p>On-going maintenance</p> <p>Labour (voluntary + employed)</p>
Residential care		<p>Upgrading, establishment and expansion costs</p> <p>Residential care subsidy for those that meet qualifying criteria</p>

## Main fiscal factors

There is sufficient indicative data on the relationship between health and housing to include health costs in the basket of costs and benefits being examined. Thus, health expenditure for older people becomes an important consideration. The relevant support services and cash benefits include:

- Personal health component of Vote:Health.
- Funding for Disability Support Services (DSS) through DHBs.
- Disability Allowance including residential care subsidy (DA).
- Accommodation Supplement (AS).
- House modification grants.
- ACC funding for house renovations required by accident victims.
- Housing advisory services (Enable).

In the 2002/03 fiscal year, AS expenditure (across all age groups) totalled \$706 million, while DA spending (again across all age groups) totalled another \$241 million. Approximately 6% of AS and 48%<sup>8</sup> of DA recipients also received New Zealand Superannuation. On this basis, \$40m of AS and \$115m of DA spending accrues to people aged 65 and over. In 2001 3.9% (or \$43m) of ACC expenditure on treatment, rehabilitation and support was for people over 65. This suggests that ACC spending on house renovations for people over 65 would have been well below \$30m. However, amongst these items, by far the largest categories are in the Vote:Health.

**Table 31 Indicative numbers for spending related to older people**

<b>Item</b>	<b>Spending related to older people (2002/03 \$m)</b>
Accommodation Supplement (AS)	40
Disability Allowance (DA)	115
ACC for house renovations	<30
Personal Health	1,715
Disability Support Services (DSS)	1,043

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<sup>8</sup> Living Standards of Older New Zealanders Survey.

## **Personal health expenditure**

While personal health expenditure is less directly related to housing options than the DSS component, there is a clear link to age, with per-capita spending rising noticeably by age. \$1,715m of personal health spending, or 35% of the total, is attributed to the over 65 age group. In raw numbers, a 1% improvement in the health status of older people, leading to a 1% reduction in health service needs, could lead to an annual fiscal benefit of the order of \$17m. From the individual's perspective a 1% health benefit represents only \$7 to \$9 per annum (Table 26). The message is that such savings may not seem significant when from the individual's perspective, but they are much more significant to broader community wellbeing.

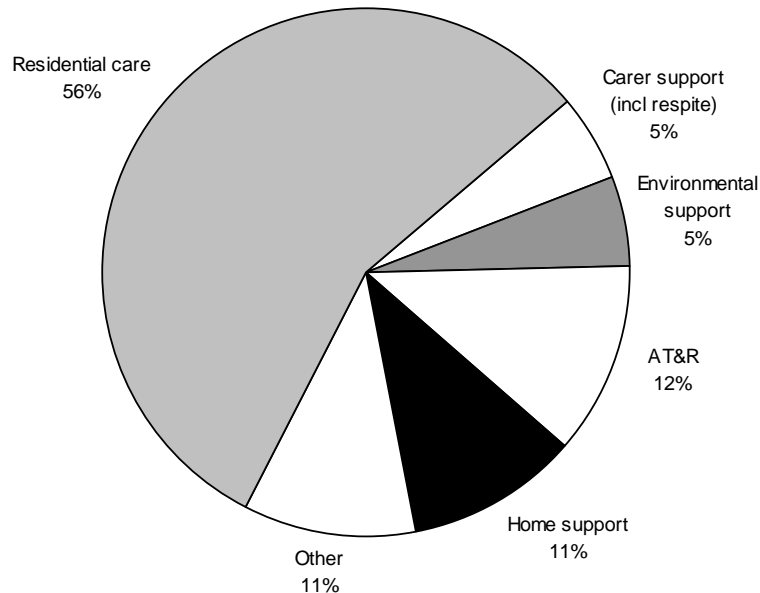
Clearly, any marginal improvement in the health status (and consequent reduction in the health service needs) for the older population could potentially realise significant benefits from the government's perspective. Coupled with other 'intangible' benefits for individuals (improved wellbeing and participation), this must improve overall wellbeing. The key is in relating this to housing options - will the general health status of older people improve if their accommodation options are improved and/or made more appropriate to their requirements?

## **DSS expenditure**

In broad terms, around 16 % of Vote:Health is assigned to DSS. Of this, nearly 70 % (or \$1,043m) can be attributed to DSS for older persons. Approximately 56 % is spent on residential care, about 11 % on home support and the remainder on a combination of environmental support, carer support, AT&R (assessment and rehabilitation) and other services (Figure 10).

Unlike spending on personal health, DSS expenditure is clearly related to accommodation options. Combining health service and census housing tenure data suggests that nearly \$575m of DSS provision goes to people in private dwellings (own home or rented) and \$478m to those in non-private dwellings, predominately residential care.

**Figure 10 DSS expenditure composition**



Source: Ministry of Health 2003.

Assuming that there is no difference between homeownership and renting, the \$575m is split as follows: \$36m for older people renting from a TLA or the HNZC ; \$77m for private renters and \$460m for older homeowners. Despite recent policies to encourage home-based support services, DSS expenditure continues to be concentrated on residential care, meaning that the greater part of DSS expenditure for older people is spent on 6% of the over-65 population – those living in residential care.

In per-capita terms, DSS provision for older persons in 2003 was about \$1,330 for those in private dwellings compared to over \$15,400 for those in residential care. The per-capita averages were \$1,420 for TLA tenants, \$1,340 for HNZC tenants, \$1,400 for private sector renters and \$1,310 for homeowners. The differences arise from the composition of the population in each of these categories. In particular, the higher figure for tenants arises from the higher proportion of women in this category (ref Figure 3). The differences in per-capita figures suggests that the distinction between renting and owning is less important than that between living in the community and in residential care.

Under the assumptions adopted, if there were a 10% reduction in the incidence of disability among older people living in rental property, this would lead to an \$11m annual reduction in DSS expenditure for tenants.<sup>9</sup> However, a 10% reduction in numbers in residential care (with a comparable increase in numbers in private dwellings) would result in a net annual reduction in DSS costs of the order of \$35m.<sup>10</sup>

People aged 85 and over comprise more than half of the 24,000 older people in residential care. Coupled with the higher per-capita spending on this group (in part, related to the gender balance), an estimated \$340m of the \$440m DSS expenditure on older people in residential care accrues to people 85 and over.

## **Intangibles**

It is important to state that modelling which identifies fiscal benefits from a reduction in residential care and an increase in community living should not be seen as an argument for ‘de-institutionalising’ the older population. Any such suggestion must be tempered by consideration of non-fiscal and intangible factors, such as independence, security, wellbeing and quality of life. Intangible factors are not covered in this section purely due to their difficulty of measurement. They are, however, examined elsewhere in this report. Any reduction in residential care provision must be matched by adequate alternative options in terms of both housing and care. Such options could be funded by resources which have been freed up in this way. Unless this occurs, then the impact on overall wellbeing will be negative.<sup>11</sup>

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<sup>9</sup> That is, another \$3.6m for TLA and HNZ tenants and another \$7.7m for private sector tenants.

<sup>10</sup> Depending on eligibility assumptions, there may also be a proportionate reduction in Disability Allowance costs.

<sup>11</sup> These observations are reinforced by overseas studies (Rodgers 1998) of jury trial awards for accident and injury compensation indicating the value placed on emotional and quality of life components accounts for a much larger component of overall wellbeing than wage earnings and/or costs associated with lost income opportunities

## **Chapter 3. International Review**

This chapter reviews examples from New Zealand and overseas which should be considered to increase accommodation options for New Zealanders as they age. These have been arranged along the continuum from totally independent accommodation to options incorporating high levels of support. Options which enable older people to stay in their own homes are first discussed, followed by options for those who choose, or need, to move to more supported accommodation. Service provision for older people also represents such a continuum. While most older people prefer to stay in their own homes rather than move, information on their options is often limited. This section therefore concludes with an overview of services designed to disseminate information to older people effectively.

### **Staying put**

The ability of older people to age in place depends on a range of factors, which are covered in this section. They include the design of their homes, the ability to adapt or renovate, and to use assistive technology. Mobilising home equity and home-sharing are other options for people.

### **Design features**

#### **Lifetime homes**

The Lifetimes Homes concept was developed, in 1991, by a group of housing experts who had come together as the Joseph Rowntree Foundation Lifetime Homes Group, out of concern about the quality of British housing and in particular how inaccessible and inconvenient many houses were for large segments of the population - from those with young children through to frail older people and those with temporary or permanent disabilities.

Lifetime Homes have sixteen design features that ensure a new house or flat will meet the needs of most households. The emphasis is on accessibility and design features that make the home flexible enough to meet whatever comes along in life: a teenager with a broken leg, a family member with serious illness, or parents carrying in heavy shopping and dealing with a pushchair.

While not yet obligatory in England, all new social housing in Northern Ireland and Wales must be built to Lifetime Homes standards.

In the mid 1990s the British Government indicated its wish to extend Part M of the building regulations, which covers accessibility, to cover houses as well as public buildings. The resulting regulations came into effect for all housing built after October 1999, reflecting some design features of the Lifetime Homes standards. Part M is currently under review again. Full incorporation of the Lifetime Homes standard is being considered (UK Parliament 2004). The Joseph Rowntree Foundation estimate that the use of these standards in all new housing will save £5.5 billion over sixty years. These savings come from reduced expenditure on adaptations and reduced need to move people to residential care. There would be further savings in health care and re-housing costs.

Illustrated examples comparing current Part M requirements and Lifetime Homes standards can be found at <http://www.jrf.org.uk/housingandcare/lifetimehomes/partMandLTH.asp>

### Senior Citizen Label, Netherlands

In 1991, upon the initiative of the Steering Committee for Experiments in Public Housing (SEV) and Dutch associations, the Senior Citizen Label was adopted and defined as a ‘consumer quality certificate for housing for older people’ (OECD 2003). It was created because an increasing proportion of new housing and building renovation was specifically intended for older people, and because of the expressed desire of older people to live independently.

In order to be eligible for the Label (ie to be designated as ‘suitable’ for older people) building projects must satisfy 31 basic requirements, based on four principles.

- Flexibility. People living in the dwelling should not have to move if disability occurs

#### Lifetime Homes Standards

- 1 Parking space capable of widening to 3300mm
- 2 Minimal distance from the car park to the home
- 3 Level or gently sloping approach to the home
- 4 An accessible threshold that is both covered and well lit
- 5 Halls and doorways wide enough to allow wheelchair access
- 6 Turning places for wheelchairs in the ground floor living spaces
- 7 Living or family room located at entrance level
- 8 Identified space for a bed at entry level
- 9 A toilet located at entrance level, both accessible and with room for a downstairs shower to be installed as required
- 10 Walls that can accommodate adaptations
- 11 An identified space for a house lift to upstairs bedrooms
- 12 Provision for a stair lift to be installed when needed
- 13 Easy route for a hoist between the bedroom and bathroom
- 14 Bathroom laid out so that it provides side access to the toilet and bath
- 15 Low window sills
- 16 Power sockets and light fixtures

in old age.

- Cost neutrality. The total cost of the requirements should not be higher than normal.
- Importance of the environment. Not only the dwelling, but also the building and the neighbourhood must be considered. For example, the Label implies accessibility within the building as well as accessibility to shops and public transport.
- Space for 'local accents' (ie local requirements). The set of requirements is not absolutely rigid.

Senior Citizens' organisations have set up a joint office which is responsible for the organisation and further development of the Label requirements. The Office also includes a national pool of auditors who inspect a potential Labelled building before and during construction. The Label can be delivered only when the building is completed (OECD 2003).

## **Home modifications**

Modifications to homes may be necessary to assist older people to remain living there safely and with a reasonable level of independence. Delivery and quality control of home modification services varies worldwide. In the UK Home Improvement Agencies operate in most local authorities. They are government funded to help 'older, disabled and vulnerable people' to remain independent in their own homes. Pynoos (1998) notes that in the USA the delivery system for home modifications is a patchwork of fragmented and uncoordinated services with significant gaps in types of services and geographic coverage.

In New South Wales, the Department of Ageing, Disability and Home Care funds, through the Home and Community Care (HACC) programme, 116 services to deliver Home and Modification Maintenance services at a cost of A\$19 million in 2002/2003. Quality control is an emerging issue, with the development of a web-based clearinghouse to disseminate information. Home modifications may involve the retro-fitting of smart or assistive technology.

## **Home Improvement Agencies: - United Kingdom**

The Home Improvement Agency (HIA) movement began in the UK in the 1970s and grew through the 1980s with government encouragement. HIAs are small, non-profit-making bodies managed locally by housing associations, local authorities or charitable bodies such as Age Concern. Care and Repair England was one of the early HIAs, established in 1986 to promote and develop 'client-orientated schemes to help vulnerable people address their housing needs' (ODPM 2002a). The Government began supporting HIAs in 1986, and in

1991 provided funding for a national co-ordinating body. Care and Repair England took this role until April 2000, when it was succeeded by Foundations. Government grants are paid to local authorities towards the provision of services to make a property fit the needs of its occupant(s). Government also pays 30-40% of the running costs of 227 HIAs (covering 284 English local authority areas), with the balance being met from local contributions and fees.

Funding to HIAs is currently in the region of £8.5 million a year. HIAs deal with around 98,000 enquiries from vulnerable householders each year, resulting in 38,000 jobs, with a total value of over £85 million (Foundations 2004). The core functions of HIAs are:

- to help older, disabled and vulnerable people to remain independent in their own homes by identifying necessary repairs and improvements, finding suitable contractors and ensuring the work is properly carried out
- to help people to access public resources, including disabled facilities grants, where available
- to help people make use of other sources of funding through information on loans, insurance and equity release.

From 2003/04, central funding support for HIAs will be provided through the *Supporting People* integrated budget. In making this shift, the Government has signalled its recognition of HIAs as an integral part of the *Supporting People* programme, and the ‘strides that agencies and their champions have taken since the formative years of the 1970s’. However it also imposes high standards on the agencies and Foundations has been engaged to develop a model accreditation system for HIAs (ODPM 2002a).

Central Government has also signalled its disquiet at the low profiles of HIAs, and the lack of national coverage. The government contract with the co-ordinating body, Foundations (to March 2004), included requirements to raise awareness among local authorities which do not currently sponsor an agency and to provide advice on the establishment, management and development of HIA services.

## **Assistive and smart technology**

There are various definitions of assistive technology and various ways in which it can assist older people to live independently. Originally focussing on disability, the emphasis is now moving to one that concentrates on preserving and maintaining independence. Tinker (2003)

provides examples of both paradigms. She offers a 1991 definition: ‘devices and techniques that can eliminate, ameliorate or compensate for physical limitations’. Wheelchairs are examples of this type of assistive technology. A more recent definition was used by the Royal Commission on Long Term Care in 1999:

Assistive technology is an umbrella term for any device or system that allows an individual to perform a task they would otherwise be unable to do, or increases the ease and safety with which the task can be performed.  
.... The aims of AT are to allow older people to maintain their autonomy and dignity; to enable pursuit of self-fulfilment, to allow an independent life and valued membership of society.

Tinker et al (2003) note that smart technology is not the same as assistive technology, although some assistive technology is smart. The most common items of assistive technology are alarms, level thresholds, grab rails, raised seats for toilets and raised beds (Tinker et al 2003).

There is increasing interest in the use of smart assistive technology, and its use in housing for older people is still very much in the experimental stages. In the United Kingdom, the West Lothian Council is undertaking a new support and care programme for older people, involving smart technology in existing homes and in newly built housing complexes (Bowes and McColgan 2002). Evaluation of this project is on-going, and will continue until 2005.

Smart features that are becoming increasingly common in the UK in older people’s housing include video-entry phones, automatic taps, door-openers, alarms in every room, and automatic lighting systems (Tinker et al 2003). The West Lothian project includes door-entry systems and fall detectors. Smart homes, as developed by the Joseph Rowntree Foundation, are described in the text box.

**Smart Home** describes a home with electronic and computer controlled technology that operates many of the installed devices and features either automatically or by deliberate control. Typical features include:

- door and window openers
- heating
- lighting
- security devices
- telephone
- video surveillance.

Smart home demonstration sites, developed with the specific needs of older people in mind, have been established at Hartrigg Oaks by the Joseph Rowntree Foundation in York and in Edinburgh (in association with Edinvar Housing Association). Additional features of these homes included:

- memory joggers and diary facility
- lifestyle monitoring
- medical monitoring
- dementia care (Edinburgh).

Changes in health status can be diagnosed, and an appropriate response triggered automatically.

Technical details of smart home technology can be found at <http://www.jrf.org.uk/housingandcare/smarthomes>

Research recently undertaken by Kings College London and the University of Reading<sup>12</sup> concluded that current developments in alarms, monitors and sensors have great potential for addressing safety and security needs, and should be introduced before people are ‘too old, when it may be difficult to learn new and quite complex procedures’ in order to obtain the benefits of monitoring and alarm systems (Tinker et al 2003). Tinker et al suggest that such assistive technology should be regarded as an ‘investment for the future’. The researchers assessed the cost-effectiveness of assistive technology to help older people stay in their own homes in the face of increasing frailty and disability. They focussed on 82 different properties throughout Britain and assessed them in relation to the needs of seven hypothetical older people with different types and degrees of disability, now and in five years time (when their disability level has increased). They found that the higher the level of disability, the sooner the savings are achieved and the more money is saved. Savings appeared to be achieved regardless of the degree of informal care also provided. However, they also found that ‘tweaking and adapting’ homes could meet the needs of most people (Housing Today 2004).

While smart home technology has the potential to bring a range of benefits to older people, and to improve their quality of life, its expense means that, without subsidy, it is not likely to be a viable option for older people on low incomes. Where it is used, care must be taken to ensure that that automated monitoring does not lead to further isolation of older people. Bowes and McColgan (2002) note that human care and technology are *not* alternatives. Fisk (2001) raises ethical issues in relation to the capacity of the communications systems used, and the ‘extent to which such responses are automated - that is, without information being sent to and mediated by a third party or central computerised facility’. Such concerns would clearly need to be addressed.

A further cautionary note is sounded by Tinker (2003). She warns:

There is little point in having sophisticated assistive technology if the home of the older person is not suitable, such as being inadequately heated or electrically dangerous. The provision of appropriate housing must always be a priority.

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<sup>12</sup> Published in April 2004 by the Institute of Gerontology King’s College London, as *Introducing Assistive Technology into the Existing Homes of Older People: Feasibility, Acceptability, Costs and Outcomes* (ISBN 1-872342-17-5). Reported in Housing Today (2004), Tinker (2003) and Tinker, McCreadie and Lansley (2003).

## Equity release schemes

The first home equity release programme launched in New Zealand - the Housing Corporation's 'Helping Hand Loans' - restricted the use of released funds to housing-related costs (Davey 1995). This scheme provided lump sums or regular advances to people over 65, who owned their homes mortgage-free and whose other assets were modest. However, the scheme was overtaken by changes in housing policy, following the change of government in 1990, and was never extended.

Reverse mortgage products, also incorporating the roll-up approach, with both annuities and lump sums, were marketed through the Invincible Life Assurance Company (now acquired by SAI Insurance) from 1992. The size of monthly payments depends on the age of the annuitant (or the younger of a couple) on entry. Take-up of these schemes has been extremely low.

Within the last year, two new equity release schemes have been launched in New Zealand - Sentinel – Lifetime Loan (Auckland based) and Avon Investments– Lifestyle Security (Christchurch based). Both offer tax-free lump sums through registered first mortgages on the property. Interest is compounded, with no repayments until the house is sold, usually when the borrower(s) dies or goes into long-term care. Being lump sum, rather than annuity based, makes them more attractive from a taxation point of view. Both have guarantees that no negative equity will be accrued and that the maximum repayment will be limited to the open market value (net realisable value) of the house when it is sold. In both cases clients must receive independent legal advice and are responsible for the upkeep, rates and insurance of the home.

The schemes vary in their fees and how they are paid, and in the ways of linking the variable interest rates to current rates. People are able to borrow a percentage of the house value based on their age(s) – both schemes allow roughly 20 percent at age 70 and 40 percent at age 90. The sums can be taken on more than one tranche, similar to a personal line of credit. This means that people are paying interest only on what they need at the time. The estimates are that around half of house value will remain at death, but this will depend on its location, trends in house prices, and how long the resident lives.

The providers suggest that clients can move the scheme to another house so long as the loan secured over property of equivalent value; the arrangement can apply to a home in a trust or with an existing mortgage (if the loan can clear this). Work continues on applying the

schemes to 'license to occupy' tenure in retirement villages and how a rates roll-up would sit alongside a home equity loan. There are no limits on the use of the sums. Publicity from the providers suggest uses such as improving lifestyle, making capital purchases (car), house improvements, unlocking part of inheritance for children and grand-children, medical treatment, large annual bills (rates, insurance), setting up children in business. Early indications show considerable interest in these schemes.

A great variety of equity release schemes are in operation in Europe, North America and Australia (Davey 1998a). They come in two main types: mortgage based schemes and home reversions. In the former, mortgages are used to provide lump sum payments, line of credit or to buy life-long annuities. Interest repayments are 'rolled up' until the house is sold. In reversion plans, houses are sold at a discounted rate to investors, either wholly or partially, but the resident retains occupancy rights for life. Reversions provide either an annuity, cash sum or mixed annuity and lump sum payments. These schemes can be done on a personal basis through legal agreements, such as the French *viager* concept.

## Homesharing

Older people may elect to share their home or move into the home of another older person under a shared housing scheme. It is not necessary for both occupants to be older people, and frequently they are not.

**Homeshare International** is a worldwide programme which originated in the USA in 1953, and now has partners in Austria, Australia, Canada, the Czech Republic, Germany, Spain and the UK. The schemes are managed by specialist non-profit agencies that match older householders with homesharers. Matching is based on needs and abilities of both. For example, the householder may benefit from companionship, security, particularly at night, help around the house, and low levels of supervision. The homesharer may be a student who benefits through free accommodation and somewhere warm and safe to study.

Screening and back-up is provided before a couple is matched up and after they are placed to ensure the success of the arrangement. The usual procedure for Homeshare agencies is to interview both halves of the potential sharing arrangement, to check references and proof of income, to make referrals so that the potential householder and homesharer can meet and interview each other. Once homesharers are matched they are contacted regularly and mediation and problem-solving services are offered. Individuals in shared housing schemes

who have specific needs are also linked with community resources and services for further support.

Benefits of homesharing include:

- 'At-risk' older people who might otherwise be in residential care, can remain in their own homes and involved in their local community
- The gap in community support services of affordable overnight support is filled
- Allows older people to give, share and contribute to others from their own life knowledge and experience
- Provides younger people of integrity with an opportunity to contribute to the wellbeing of an older person in return for secure, affordable accommodation
- Promotes intergenerational communication and understanding
- Families of both householders and homesharers report a considerable decrease in their anxiety, knowing that their family member has caring support.

**Homeshare NSW – Australia** began operations under the auspices of the Benevolent Society in early 2000. An initial trial period was funded by the NSW Ageing & Disability Department (now the Department of Ageing, Disability and Home Care), through a one-off grant of A\$100,000 from International Year of Older Persons funds, and the Department of Veterans Affairs with a grant of A\$28,000.

Between May 2000 and February 2001, Homeshare NSW made 14 matches involving 12 householders and 14 homesharers. An external evaluation by Brian Elton and Associates (Homeshare NSW 2001) found that eight matches were successful, and of the three that were not, lack of success could be attributed to unsuitability of one party in only one case. The evaluation was reported before sufficient time had passed for the success of the remaining three cases to be assessed. The programme was allocated a further A\$340,000 with a target of 30 matches by June 2003. A further evaluation was due for completion by the end of 2003<sup>13</sup>.

It is expected that this evaluation will address the following issues:

- the process and outcomes of the matches undertaken by the Benevolent Society, including materials developed for the programme
- the broader applicability of Homeshare beyond the pilot phase
- an appropriate fee structure for the programme if it was to be expanded
- the value of training provided to other aged care providers

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<sup>13</sup> This was not available on the website 02 June 2004.

- an assessment of the interest of other aged care providers in receiving training and using the Homeshare model as part of their services
- an assessment of the possible expansion of the Homeshare model to regional and/or rural NSW.

**Homeshare Victoria - Australia** has been developing in Melbourne since March 2000. Originally under the auspices of Mecwa Community Care, it is now managed by Wesley Mission Melbourne. By late 2003 fifty-one matches had been made. Homesharers in the Victoria programme have ranged in age from early 20s to early 70s. They have included professionals, semi-retired people and mature age students. All are on reduced incomes and report benefits from the life experience of the older person and the secure, low cost, reasonable quality accommodation. Householders have been both male and female. Nearly three quarters have been over the age of 80, and nearly one quarter over the age of 90. They have come from all walks of life and confirm that they would not have been able to remain at home without the homesharer (Homeshare Victoria - Australia 2003).

## **Moving to alternative accommodation**

Moving from a familiar environment can be stressful, particularly for older people. This section begins by reviewing a programme operating in the USA that assists older people making the move to supported accommodation. It continues with a review of accommodation models designed specifically for older people, catering for varying degrees of support and with different tenure arrangements. Two broad models have emerged. Dwellings may 'pepper-potted' within the wider community or clustered together as a 'village'. Dispersed options discussed in this section include:

- co-housing communities where relatively fit and independent older people live together
- secondary accommodation options, such as granny flats
- sheltered accommodation options
- extra care housing, where quite high levels of care can be provided.

Two main forms of 'villages' for older people are reviewed -

- The 'social village' which seeks integration with the wider community.
- Self-contained retirement communities.

## **Moving Buddies**

Moving Buddies is a volunteer programme, operating across the USA, that provides both emotional support and practical assistance to older people who are making the move to a supportive living scheme.

The Moving Buddies Program helps make a very difficult transition less frightening and overwhelming, especially for older people who have no support systems of their own. This allows elders to continue to live with dignity and as independently as possible (NCOA 2004).

Volunteers are matched with older people to assist them through the entire moving process. The support continues until the older person is settled into the new environment. They assist with:

- making decisions about what items to keep and what to discard
- organising and arranging the sale of unneeded furniture
- hiring and supervising a moving contractor or company
- packing and moving.

The programme is linked to an assisted living or supportive facility. A programme co-ordinator is identified to recruit and train volunteers. Guidelines suggest that for a 100-unit facility, the co-ordinator should anticipate training 20 volunteers in the first year, and build to a pool of 40 over two years. The programme co-ordinator also takes responsibility for identifying 'low to moderate-income frail elderly' who need assistance in moving. Those without family or other supportive networks are given first priority, and, where possible, those who cannot afford to hire private case-managers or moving specialists are also assisted.

## **Housing 'pepper-potted' within the community**

Various forms of housing specifically for older people are designed to fit discreetly into the community. Models described here range from those where the older person requires very little support to those where high levels of care are required.

## **Co Housing Communities**

This approach to housing was developed in the Netherlands, Denmark and Germany. A

CoHousing Community has been defined as ‘a cluster of friends and neighbours in their own homes, loosely associated with each other for a common purpose’ (Brenton, 2001). The formation and development of the community is led by the group itself. The co-housing approach allows residents to maintain their privacy and independence while being connected with a group of people who share some common spaces and who have chosen to form the housing/community group. While these developments vary in size and design they share a number of features:

- Common facilities
- Private homes
- Resident-structured routines
- Resident management
- Design for social contact
- Resident participation in the development process
- Pragmatic social objectives

CoHousing Communities have a focus on mutual support among their members. Generally people who set up these communities are relatively fit and healthy, self-reliant, of mixed ages (usually 55-70 years) and include both couples and single people. The benefits are independence, having a private home, whilst being surrounded by people who support and socialise with you and with whom you chose to live. In the Netherlands, with its ‘robust network of local old age unions’ and a climate ‘which values participation and citizenship’ (Brenton 2001), CoHousing for older people has been officially encouraged at all levels.

In Gronbo, Denmark, a CoHousing initiative has been developed where older people have worked with a building society and a group of architects to select the site and to design their future homes. The houses are planned to cope with future levels of fragility and the environment selected for its convenience to shops, transport and other facilities (OECD 2003).

CoHousing is also increasingly being used in Canada, where most communities are organised as condominiums, making it easier to obtain financing. Residents purchase an interest in their unit with common elements (eg laundry, garden area) co-owned. Residents pay monthly fees to service the debt on the common elements and to cover operating costs, maintenance and repairs. When members move, they sell the units on the open market. Prospective members are encouraged to spend time in the community before they move in, to ensure they are

compatible (OECD 2003).

There is a broad CoHousing network in Britain, but very few co-housing communities, which are all family-based (Brenton 2001a). However, it is a developing option for older people, with a small older women's group in South Wales, an 'embryonic' group of older women and men in Bristol, and the Older Women's CoHousing Project in London (Brenton 2001a), which is described below.

### *Older Women CoHousing Project, London*

A pilot project to develop a co-housing community is currently underway with a group of women aged 50-76 years in London. The Older Women's CoHousing Project was established in 1998, by a small group who were introduced to the concept at a workshop sponsored by the Joseph Rowntree Foundation. They aim to build a community along the lines of a model developed by older people in the Netherlands. Two challenges have faced the group: - one is developing a sense of group solidarity and community in preparation for living together (and to sustain this over the long term), and the other is in finding a site and the necessary finance to develop or renovate the building(s).

The group envisages around 24 individual apartments with a common room, workroom and guest room and a garden in any part of London within the free transport (for older people) area. It is expected that there will be a mix of tenures within the community. Some women will own their flats, others will part-own and part-rent, while some will fully rent. The rented accommodation will be owned by the housing association, Housing for Women, which has been in partnership with the project since 1999 (Brenton 2001a). The group is also supported by the Joseph Rowntree Foundation who have funded Maria Brenton as a part-time research consultant for the group. The UK Housing Corporation also has an interest in the project, and has funded research into the legal and financial possibilities of co-housing for older people. It is also keen to test the potential of the mixed tenure scheme (Brenton 2001a). This is one of the few housing developments found in this review that is specifically for older women.

## **Secondary dwelling options**

Different types of secondary dwellings are available for older people who wish to relocate near family. A secondary dwelling may be either

- self-contained, as in a modular, relocatable 'granny flat', or

- an accessory unit. An accessory unit is a separate dwelling created out of extra space within, above or on the property of a single family house, or even a garage.

In many parts of the world, secondary dwellings are discouraged, if not outlawed, by restrictive rules and regulations. Jowett (2003) notes that in Britain, older people living in granny flats may be ineligible for assistance, such as help with council tax or rent, and they may lose income support and housing benefits. In many areas of the USA secondary dwellings are prohibited by zoning laws. However, in places where they are allowed, such as Portland, Oregon, they provide affordable housing and result in a more resource-efficient development pattern across the city. In Seattle, Washington, secondary apartments are allowed only if they are in the principal structure rather than physically separate (Jowett 2003).

### *Self-contained units*

According to Jowett (2003) the first moveable granny flat programme originated in the Australian state of Victoria in 1975, where the flats were (and are still) leased by the state government. The modular units are assembled where and when they are required, and dismantled when the need has passed.

In the USA and Canada the term for a dwelling of this type is ECHO Housing, ‘perhaps because ‘granny flat’ was deemed a pejorative term’ (Pynoos 1999). ECHO stands for Elder Cottage Housing Opportunity. ‘Garden suites’ are a form of ECHO housing developed in Ontario, Canada, as ‘an independent alternative to the high cost of dependent institutionalisation of older people’ (Jowett 2003). They are temporary, one level, relocatable free-standing dwellings with one to two bedrooms, built to the side or rear of an existing single dwelling. A garden suite has a licence for a set time period, and once it is no longer needed by the original occupant it must be removed.

### *Accessory Units*

‘Homecare Suites’ have been developed by a company in Kansas, USA (Howe 2001). These modular units are designed for the ‘frail elderly’ ... who ‘would otherwise require institutional care’ (Jowett 2003) and are inserted into an attached garage. Installation takes seven to ten days, and removal only 48 hours. In 2001, the unit retailed for US\$30,000, and was also available for rent. Units are available with or without kitchens. The absence of a kitchen is necessary in some municipalities that do not allow secondary apartments (Howe

2001).

## **Sheltered housing**

Sheltered housing has been described in the UK as one of the main ‘moving options’ for older people, who need support but wish to remain living independently (DETR 2001). It is provided by both the public and private sectors on the basis of rental, purchase or shared ownership. It is designed for easy delivery of health, care and support packages, so that older people who move into a scheme can, wherever possible, remain there for the rest of their lives. An framework known as the Code of Practice (COP) was recently developed because of concerns at the varying standards of sheltered housing throughout the UK.

There is a range of definitions and descriptions of sheltered housing. In general a sheltered living scheme in the UK consists of groups of between fifteen and forty dwellings with some communal facilities. These usually comprise a lounge, a laundry, garden and a guest room. While most providers of sheltered housing do not provide care, they should be able to assist residents to access care if and when required. A warden or manager usually lives on site or nearby, and an alarm system, linked to the warden, provides a measure of safety and security. The warden provides low level monitoring of residents as well as a link with the housing provider. Twenty-four hour emergency assistance is available through the connection of each flat to a call centre. These are often known as Category 2 schemes.

There are also grouped housing schemes without the services of a warden and other communal facilities – commonly known as Category 1 schemes. The UK Housing Corporation recently concluded that such categories are often not useful to older people in accessing suitable housing and services, and that schemes need to be described in terms of property, environment, purpose and philosophy (DETR 2001). An example of a local body provider of sheltered housing in the UK is the London Borough of Camden. Camden was awarded Beacon status<sup>14</sup> by the British government for services to older people.

Similar schemes exist in the USA and in Canada where they are known as supportive or congregate housing, and in Europe. In France they are known as logement-foyer (Frossard et al 2002), and in the Netherlands, woonzorgcomplexen (Ex et al 2003).

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<sup>14</sup> The Beacon Council scheme is concerned with achieving improvements in the delivery of local government services. An award is granted to demonstrate that councils are providing services to a high standard within a particular theme. In 2001/02 one of the themes was older people – supporting independent living for older people. Councils which achieve Beacon status are expected to share examples of their best practice with others.

**Table 32 Sheltered Housing Code of Practice (COP) United Kingdom**

An externally validated quality framework for providers of sheltered housing in the UK is operated by the Centre for Sheltered Housing Studies (ODPM 2004). The COP is awarded to the whole of the sheltered housing service provided by the organisation concerned and is valid for three years.

Core objectives assessed for the 2003 version of the COP are:

- Service users have support plans based on up-to-date assessments of need. Processes place users' views at the centre, are managed by skilled staff and involve carers and/or other professionals if service users wish.
- The security, health and safety of all individual service users and staff are protected.
- Service users have the right to be protected from abuse and this right is safeguarded.
- There is a commitment to the values of diversity and inclusion and to the practice of equal opportunity (including accessibility in its widest sense) and the needs of black and minority ethnic service users are appropriately met.

Supplementary objectives are covered under the broad headings of:

- empowerment (of service users)
- rights and responsibilities (such as awareness of complaints procedures)
- service (including environmental aspects).

Certificates of Code of Practice achievement are awarded for ten standards. These are:

- 1 Equality of Opportunity and Diversity
- 2 Rights and responsibilities
- 3 Confidentiality
- 4 Independence and Empowerment
- 5 Service delivery, Review, and Continuous improvement
- 6 Professional role and responsibilities
- 7 Collaboration and community development
- 8 Trained and supported staff
- 9 Policy and Legislation
- 10 Physical environment.

In New Zealand, the concept of sheltered housing is not well developed. However, a number voluntary groups and social housing providers incorporate its attributes. This section describes 'sheltered housing' provided by Compassion Housing, Upper Hutt; Abbeyfield, the Ouae Marae Trust in Waitara, and two local authorities: New Plymouth District Council and Christchurch City Council.

#### *Compassion Housing, Upper Hutt*

In June 2000, Compassion Housing Ltd, a charitable company of the Sisters of Compassion, bought the Upper Hutt City Council's stock of pensioner housing. The council perceived that other providers were in a better position to provide an integrated service to the residents. The

Sisters have a strong presence in Upper Hutt where they have provided rest home, respite and hospital level care at St Joseph's Home of Compassion for nearly 70 years. Purchasing the units gave them an excellent opportunity to provide a greater level of outreach services to older people in the community.

Compassion Housing's rental units are available for older people, or for other beneficiaries over 50, who need affordable accommodation. Preference is given to applicants with less than \$60,000 combined assets. However, all entry criteria may be varied from time to time, depending on needs and availability of accommodation.

Compassion Housing's Services Manager maintains a visible presence around the complexes, visiting residents regularly, dealing with maintenance, and generally ensuring that residents are able to maintain their independence. His role description includes

- ensuring residents are able to experience a quality of life that enables them to live their lives with personal respect, safety and dignity
- arranging for regular assessment of residents and matching their needs with services and entitlements from the community
- managing relationships with community and government agencies supporting older persons.

Compassion Homes employs a registered nurse from St Joseph's Home of Compassion to monitor the needs of a small number of residents who have been identified as being at risk of losing the ability to remain independent. There is no extra charge for this service. Tenants who are unwell have the option of using the Home of Compassion rest home facilities on a temporary basis. However, this does not seem to be used widely, with tenants more likely to remain in the flats before making a more permanent move into residential care.

Rentals are kept purposely low. Compassion Homes is a not-for-profit venture. Rentals for mid-2004 are shown below.

Accommodation type	Weekly rental
• Bed-sit villas (12)	\$85
• One bedroom villas (73)	\$105
• Two bedroom villas (3)	\$140
• Two bedroom house (1)	\$185
• Three bedroom houses (3)	\$220

Most of the units are in groups of 7-8, in nine separate locations in Upper Hutt. The Services Manager believes that this is a good model, in that the older people are not cut off from the rest of the community.

### *Abbeyfield Houses*

Abbeyfield was established in England in 1956, with the goal of providing affordable family-style housing for older people seeking independence, companionship and safety. There are now Abbeyfield societies in thirteen countries, providing over 900 houses worldwide (Abbeyfield NZ 2004). An Abbeyfield house is styled as a large family home where each of the residents has a comfortable room, sharing common facilities, two meals a day and the services of a live-in housekeeper. Volunteers attend to house maintenance, gardening, and staff recruitment. As a volunteer-based not-for-profit organisation, Abbeyfield relies on the goodwill of the community and community organisations. Residents are encouraged to be active members of the House Committee. Each resident furnishes their rooms as they please, and have both their privacy and the right to invite visitors and to come and go as they please. They are supported to continue being active, contributing members of their local community and decision-makers in their own household (Abbeyfield NZ 2004).

The 'mix' of residents is a major factor in the success of an Abbeyfield house. Prospective residents trial the lifestyle by spending one to two weeks in the guest room, and the House Committee makes the final selection. Applicants are taken on the basis of need and suitability, not ability to pay. Abbeyfield houses are available to people 55 years and older, but are particularly suitable to widows and widowers over 65. The current age range of residents in Abbeyfield New Zealand houses is 70-100 years (Abbeyfield NZ 2004).

Couples may also apply to live in an Abbeyfield house. They are always given two rooms and may choose whether they would like to use one room as their bedroom and the other as their sitting room or have separate bed sitting rooms. An Abbeyfield House may be purpose built, or an existing building may be re-modelled. An Australian house was created from a disused inner urban church that was renovated and refurbished to create a three level house, complete with lift. Information on existing Abbeyfield houses in New Zealand is provided in Chapter 2.

The proposed Abbeyfield House in Hamilton is the result of a partnership between

Abbeyfield New Zealand and HNZC. The New Zealand Housing Foundation provided seeding funding to develop the proposal, and HNZC is lending funds for the construction. The Corporation receives allocation rights for five of the units, which will provide accommodation for older people currently living in large family homes, thus freeing up those homes for families in need.

### *Te Ati Awa Kaumatua Housing*

Waitara's Owae Marae Trust owns eight one-bedroom kaumatua flats, which are managed by Te Ati Awa Kaumatua Housing Trust. The flats are well supported by three local health groups, Te Maunga Hauora, Maori Women's Welfare League and Taranaki Base hospital. The units are sited on the banks of the Waitara River, close to town and in easy walking distance of the Owae marae. The flats are attractive and have their own individual gardens. Seven of the flats are for single occupants and one caters for a couple. Seven of the current eight occupants are Maori, one is Pakeha and there is a waiting list. To qualify for entry into the kaumatua flats the applicant/s must:

- be 50 years or over
- not be a home owner
- have good health.

The potential benefits from having kaumatua living on or close to the marae included having them readily available for hui, for passing on the culture and traditions and generally 'keeping the whare warm.' Owae Marae is currently planning to build more kaumatua housing in Waitara.

### *New Plymouth District Council (NPDC)*

The NPDC's *Community Development Plan 2002-2012* includes strong support for Positive Ageing principles and outlines a number of issues and priority areas that impact on older people. Housing is 'number one' on the list. NPDC's housing stock for people 65 years and over consists of 156 units. Most were built between the 1950s and 1980s. Of the 156 units, 113 are distributed throughout the city of New Plymouth. The remaining 43 are in the small 'rural towns' of Inglewood (25 units) and Waitara (18 units). All the units were built on land owned by the Council. NPDC had considered putting its Inglewood units on the market, as they had a high vacancy rate, but this proposal was recently revoked. Plans are now

underway to refurbish and re-tenant the units.<sup>15</sup> Demand in Waitara for council housing, on the other hand, is high and the units there are quickly filled on vacancy.

Pensioner housing eligibility criteria require that the person wanting to rent is not a home owner, is in receipt of a Work and Income New Zealand benefit and has a clear credit history. People over 65 years are given first option when a unit becomes vacant. Currently the 65 plus age group account for 68 % of NPDC's housing tenants, the next biggest groups are invalid and sickness beneficiaries. Maori account for about 10 %. <sup>16</sup> In January 2004, rentals were as follows. These are well below current private rental levels in the region.

Accommodation type	Weekly rental
• Bed-sitter units	\$48.50 - \$65.00
• Single units	\$63.00 - \$85.00
• Double units	\$68.00 - \$90.00

NPDC recently upgraded its pensioner housing at a cost of around \$2 million. Exterior walls and hot water cylinders were insulated, and some bed-sitters were extended to become one-bedroom units. Despite this upgrading, some units require additional modification to accommodate wheelchair access and mobility aids. Some shower boxes are also considered unsuited to older people with disabilities. The units are generally well positioned in terms of sun and access. They are described as attractive homes to live in, particularly since the refurbishment. A relatively high proportion of tenants have regular contact with health care providers, for example general practitioners and Taranaki Base Hospital. The low demand for council housing by older people in Inglewood was attributed to its remoteness from hospital and specialist health care services.

The council's Community Development Section is contracted to provide tenancy services, oversee maintenance requirements and link tenants to social support services, as needs arise. New Plymouth reputedly has a good range of social support services available to older people. Tenants can rent cheap fridges and washing machines from the council and contractors mow tenants' lawns regularly. The Client Services Officer visits tenants on a six-weekly basis to determine if there are any maintenance issues, and generally checks on the tenants' well being.

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<sup>15</sup> Information provided by NPDC's Client Services officer 19 May 2004.

<sup>16</sup> Information provided by the Client Services Officer, NPDC.

While the NPDC is strongly committed to continuing its role as a provider of low cost housing for older people, the current status quo has not gone unchallenged. There is no guarantee that this stance will continue and there are no plans to increase existing stock to accommodate growth in demand due to population ageing. Over the past two decades, the council has followed prevailing central government social housing and monetary policies. Between the late 1980s and 1990s, a constant tension existed as to whether or not the Council should be in the business of providing social housing or low rental accommodation for older people. In 1991, for example, the NPDC debated whether to raise its rents to full market value in line with the change in government policy at that time. The consensus was not to follow suit. The Council opted instead to peg its rentals below market levels. Maintenance of the NPDC pensioner housing stock is largely in keeping with current central government sentiment and policy direction as is the council's support of the Positive Ageing Strategy.

#### *Christchurch City Council (CCC)*

CCC is the second largest social landlord in New Zealand after HNZC, with 2,650 housing units and a waiting list of 400. The council owns a wide range of housing, but 70% of the units are one-bedroom or bed-sitters. Bed-sitters are becoming harder to let and are mainly occupied by ex-psychiatric patients, because of cheap rents. This mix has caused difficulties for some of the older tenants. Traditionally CCC provided housing for elderly people, Now 65% of their tenants are over 55. Most of the rest have mental health or disability problems. There are asset and income tests for eligibility, with an income limit of \$19,000 and a limit of \$20,000 in assets.

The Council's housing policies emphasise care and concern for their tenants. The Council employs housing officers and activities coordinators who organise outings and recreation (mainly oriented to older people). The housing developments have tenants' lounges and minibuses for transport. Further measures are being considered to personalise housing and encourage social interactions among the tenants and the wider community.

The CCC is committed to continuing to provide housing for older people, and is working on a long term housing strategy, with a 30 year timeframe. Rents are being set with the intention of making housing financially self sustaining and, consequently, they recently went up by \$5 a week. However this had little effect on tenants as it was covered by the accommodation supplement. Rents are now inflation linked. As part of its long term strategy, the council has recently conducted an exercise to map housing need against housing provision, so that it can

arrive at a more appropriate pattern of provision. Sixty-two new units are planned over the next three to four years, with the intention of using HNZN funding to cover 50% of the cost.

## **Extra care housing**

Extra care, or very sheltered housing, is becoming increasingly prevalent in many countries, including the UK and Denmark. In these countries, it often replaces residential care and takes the pressure from acute hospital services, enabling earlier discharge (Colmorton et al 2003, Riseborough and Fletcher 2003). In both countries it is becoming an important element in integrated approaches to the housing, health and social care needs of an ageing population. It is also proving popular amongst older people.

In Denmark, health and social care is available on a universal basis dependent on need and not on age or ability to pay. Assistance given by family members is considered 'additional input', and 'rarely substitutes for public care' (Colmorton et al 2003). In addition, the emphasis in Denmark has moved towards de-institutionalisation wherever possible. A Commission on Ageing was established in 1979 and recommended that future policies should be guided by adherence to the principles of 'continuity, self-determination, and use of [people's] own resources' (Commonwealth Department of Health and Ageing 2003). The Commission specifically recommended the expansion of 24-hour care services for people in their own homes.

Legislation was introduced in 1987 which prohibits the construction of nursing homes, as many characteristics of these institutions are no longer considered 'acceptable' (OECD 2003), for example:

- not enough room
- concentrations of older people requiring intensive nursing
- closed off to the outside environment
- often an unsatisfactory staff-to-resident ratio.

This resulted in a decrease of 30% in the number of nursing home beds between 1985 and 1997. Municipalities concentrated instead on the development of housing more suited to the living and care/home help needs of older people. Overall it is estimated that the number of adapted dwellings increased by 331%, from 9,622 to 31,854, between 1985 and 1998 (Commonwealth Department of Health and Ageing 2003). As nursing homes gradually disappear, older people who require care are offered their own self-contained accommodation

in 'extra care' sheltered housing developments. Some nursing homes have been converted into individual 'extra care' apartments, and others are built in the 'spaces between apartment blocks', allowing older people from the neighbourhood to preserve their social and family networks while using existing amenities and surrounding services (OECD 2003).

In line with the policies of preserving self-determination, even people who require nursing home care manage their own pensions and pay for rent, electricity and services such as shaving, hairdressing, meals etc. The Danes believe that when older people have to pay directly for the services their incentives to do things for themselves increase, along with their self-determination. Nursing home staff are not expected to take over responsibility for the life of individuals. Each resident is to decide what services he or she wants to make use of. Staff are responsible for treatment, care and supervision (Colmorton et al 2003).

While there are different models of extra care housing, with different characteristics depending on provider, Riseborough and Fletcher (2003) stress that extra care housing is a *concept* rather than a type - '*extra care is housing first. It isn't an institution and should not look or feel like one*'. Extra care housing provides people with their own homes, with legal rights to occupy. It should have design features that encourage ageing in place, help people to self-care for longer, and promote independent living.

Views in Britain are mixed on whether extra care housing should sit somewhere between conventional sheltered housing and residential care, or whether it should replace residential care as a more appropriate style of provision (Department of Health [intro to commissioners] 2003). What is clear is that extra care housing is a *housing based model of care*, and requires strong partnerships between housing, health, care and support agencies at strategic, commissioning, funding and operational levels. Riseborough and Fletcher (2003) identify the main ingredients of extra care housing as principles, design, care and leisure, assessment and allocation, with quality of life (as opposed to simply 'quality of care') at the core. This is illustrated in Table 33.

Table 33 does not detail design characteristics of extra care housing, nor does it emphasise accessibility. The Department of Health's 2003 advice to commissioners of extra care housing stresses the need to consider the physical environment of any scheme:

Extra care housing has too often been defined primarily by the additional facilities it provides, ignoring the need for the whole building to support independence. This can

only be achieved through high standards of accessibility both in common areas and in individual accommodation.... Accessibility in common areas is only part of the answer and a scheme that is to be regarded as genuine extra care housing needs to comprise individual dwellings that also meet contemporary standards for space and layout.

**Table 33 Ingredients of extra care housing**

<p><b>Principles</b></p> <ul style="list-style-type: none"> <li>• Focus on individuals</li> <li>• Rehabilitation</li> <li>• Independence</li> <li>• Residents have control - tenancy rights separate from care</li> <li>• Neighbourliness</li> <li>• Access to community facilities</li> <li>• Community resource</li> </ul>	<p><b>Design</b></p> <ul style="list-style-type: none"> <li>• Individual flats are seen as ‘home’</li> <li>• Design allows for a range of social activities</li> <li>• Progressive privacy is built in for residents</li> </ul>
<p><b>Care and Leisure</b></p> <ul style="list-style-type: none"> <li>• Flexible care</li> <li>• Working with, not doing for, residents</li> <li>• 24 hour support</li> <li>• Care team based in scheme</li> <li>• Access to meals</li> <li>• Domestic support</li> <li>• Supporting social and leisure opportunities</li> </ul>	<p><b>Assessment and Allocation</b></p> <ul style="list-style-type: none"> <li>• Joint assessment and allocation</li> <li>• Balance of dependency levels</li> <li>• Positive approach to mental health</li> <li>• Step up and step down places</li> <li>• Home for life</li> </ul>

**Quality of life**

Source: Riseborough and Fletcher 2003.

While different models of extra care housing have different characteristics, a detailed list from one British provider, quoted in the Department of Health’s introduction for commissioners of extra care housing, identifies the following:

- Self contained flats with full kitchen and bathroom facilities, to mobility and usually wheelchair standards
- Staff facilities, including office and sleep-over
- Barrier free spaces which are accessible, aid mobility and are fully equipped, with lifts to all floors, or as many floors as possible
- A range of service areas for hairdressing, laundry and chiropody, etc.
- Communal areas including day rooms, catering and dining facilities offering communal meals or café services
- Guest facilities

- Good links to the local area
- Staff on site responsible for the building, management and co-ordination of care and support services
- Privacy for residents combined with services to the local area.

Another provider puts emphasis on social, educational and recreational facilities, which could also be used by older people drawn from the surrounding community (Department of Health [intro for Commissioners] 2003).

### *Broadway Gardens, Wolverhampton*

Wolverhampton Metropolitan Borough Council has a programme to replace residential care with extra care housing. Some of the former nursing homes will be converted into resource centres for community-based support, rehabilitation beds and other specialist uses. Support for this comes from the Royal Commission on Long Term Care (1999)<sup>17</sup>, which encouraged this approach as both more cost-effective and a better quality of outcome for service users.

Broadway Gardens is Wolverhampton's first example of this new approach. It is managed by a charitable trust. The model has a strong emphasis on flexible care developed from a housing base, and recreational, educational and craft facilities inspired by Scandinavian and Dutch practice. Broadway Gardens is recognised as a 'standard-setting scheme' (Department of Health [intro to commissioners] 2003).

### *Skaevinge, Denmark*

In 1984, the Skaevinge Municipality began a project to create a more dynamic and flexible system of service provision for older people. One of the results of the project was the conversion of the former nursing home into individual apartments, providing residential units. These 'resembled the type of housing that the residents were accustomed to before requiring sheltered housing' (Colmorton et al 2003). Twenty-four hour care is available to residents in the sheltered housing, and to all residents in need, regardless of the type of residence.

The project also involved the establishment of a health centre, which brought home and public health nursing, social services, and a day centre together for the first time. The resulting interaction of the social sector, with its emphasis on encouraging the older people to

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<sup>17</sup> With respect to old age: long term care - rights and responsibilities (Royal Commission on long Term Care 1999) not accessed in course of this work

do as much as possible for themselves, and the health sector, with its ‘deep-seated habits of ‘helping’ and ‘taking care of’ ... patients’, together with preventative home visits<sup>18</sup> has led to a marked reduction in the bed occupancy rate amongst people aged 75 plus (Wagner 2001). While the number of people in this age group increased by 30% over twelve years (1985-1997), staffing levels have not increased since 1986, and operational expenditure has decreased. The project evaluation found that quality of life for the older people, especially those living in the former nursing home, had increased (Wagner 2001), and that the significant improvements were due to the municipality’s emphasis on prevention, flexibility and individual health and social care (Colmorten et al 2003).

The integrated model of care pioneered by Skaevinge was widely adopted by other municipalities during the 1990s and is now used by around 75 % of them. In general, outcomes have been similar to those achieved at Skaevinge (Commonwealth Department of Health and Ageing 2003).

#### *Saint-Nazaire, France*

In 1991, a decision was made by local authorities of the Basse-Loire<sup>19</sup> and the hospital authorities of Saint-Nazaire to base the care of older people in the community. The population ageing plan formulated for the region sought to encourage the participation of older people in community life.

Although ‘conviction and determination’ were needed, to convince the institutional backers (OECD 2003), the Saint-Nazaire hospital authorities wished to restructure the 240 bed, long-term facility for the elderly, and to re-locate the older people into the community.

Six sites were made available by the municipality, and large town houses ‘well integrated into the urban fabric’ were purchased and renovated. In 1995, ten houses, each accommodating up to 25 people, were opened. All were designed following the same principles. They were built around a patio area with a common room on the town side. An enclosed outdoor area was built ‘to reassure residents’.

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<sup>18</sup> All Danish municipalities are obliged to provide for at least two preventive home visits a year from social and health workers for older people 75 years or more, with the consent of the older person. The aim of the preventive home visits is to reduce risk factors. This might be reducing falls, social isolation, suicide, traffic accidents and to improve physical activities. The municipality may also decide to make exceptional visits in relation to the death of a spouse, serious illness or discharge from hospital. The person (often a nurse) making the visit must have thorough knowledge of general social as well as health issues (Colmorten et al 2003).

<sup>19</sup> The Basse-Loire region comprises nine municipalities, including Saint-Nazaire.

All houses were sited so that the residents could be involved in the life of the community. For example, some were sited opposite a market, others near a school. The town setting and placement of the houses meant that the former long-stay hospital residents received more visitors than previously. Even people diagnosed as suffering from advanced dementia have managed to regain some independence. They are reported to be less confused in the smaller place and can find their way to their own rooms.

The health authorities report that, thanks to the support of the municipality, the cost of delivering health care to the residents is the same as previously. However, despite the success of the venture, it has not yet been replicated elsewhere in France (OECD 2003).

#### *Tregenza Avenue Aged Care Services, Adelaide*

Tregenza Avenue Aged Care Services is an innovative residential aged care complex on the outskirts of Adelaide combining the home for life approach with the ability to provide high levels of care, if required.

The complex comprises a series of discreetly linked 3 bedroom houses, which have been purpose-built to rest home standard. These are rented to older people who tend to enter the complex while they are still quite active and independent. Often older people from the same community will choose to 'flat' together. As the care needs of the residents increase, an extensive range of support services – including a level of nursing care – can be 'brought in'. The care is adapted to suit the changing needs of the resident, rather than the resident having to adapt to suit a more standardised model of care.

The complex accommodates around 40 residents, and is operated by Tregenza Avenue Aged Care Services in partnership with the Elizabeth & Districts Housing Association (a community organisation, funded by the South Australian government, providing low income housing across all metropolitan areas of Adelaide) and a domiciliary care provider. Residents pay according to their needs and according to their income (Information provided by Max Reid and the Tregenza Avenue web-site).

## Village options

### Social village

The **social village** seeks integration with the wider community by bringing the outside in, for example, by providing health or community services within the housing complex.

#### *Kobe, Japan*

Shiawase-No-Mura ('The Village of Happiness') is a unique complex in Kobe. It combines housing for older people with two college campuses: one for senior citizens within the village and from Kobe, and one for people of working age; care facilities, and extensive sport and recreational facilities which cater for around 2 million visitors annually.

Originally opened in 1987, Shiawase-No-Mura became the site for temporary group housing to ease the housing shortage in Kobe resulting from the Hanshin-Aqaji earthquake of January 1994. Its continuation as a social village for older people was an unanticipated development. The older people themselves petitioned to remain living in the temporary housing, because they like the 'communal, congenial intergenerational atmosphere' (OECD 2003).

The complex is equipped with a variety of integrated facilities designed to support independent living of both older people and people with disabilities. It also serves as a meeting place for the citizens of Kobe, to 'deepen mutual understanding and work together to create a society in which everyone can lead a full life'.<sup>20</sup>

There are facilities at Shiawase-No-Mura to promote:

- self-sufficiency and participation in society
- studying, relaxing, and exchange
- outdoor sports and recreational facilities.

Facilities to promote self-sufficiency and participation in society include a 180 bed rehabilitation hospital and an inpatient/outpatient rehabilitation facility specifically for older people, a dementia care centre, job training for people with disabilities and a day care respite facility for people with severe disabilities living at home.

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<sup>20</sup> [http://www.shiawasenomura.org/html/village\\_of\\_appiness\\_kobe.html](http://www.shiawasenomura.org/html/village_of_appiness_kobe.html)

Kobe's Senior Citizens' College, the 'Silver College' provides educational facilities for older residents (57 and older) of Kobe and Shiawase-No-Mura 'to augment their wealth of experience'. Courses include health and sports sciences, management studies, community welfare and international co-operation and exchange. Educational facilities are also available for workers of Kobe. In 1993, a respite resort hotel was opened. This provides primary caregivers with a place to relax, study, and exchange ideas. Special features of the hotel include a comprehensive display to promote the use of products and equipment for home care providers, and retrofitted apartments that accommodate the needs of older and/or disabled people. In addition, over 2 million people visit to make use of the extensive sport and recreational facilities, which are as diverse as tennis courts and a herb garden. Overnight lodging is provided for 228 people, and a campground has 200 campsites.

#### *Waimarino Elder & Care Village, Raetihi*

A partnership, developed in 2001, between the Waimarino Rest Home Trust and Presbyterian Support (Central) has led to the establishment of the Waimarino Elder Care Village in Raetihi (central North Island). This will eventually provide accommodation for 20-28 older people, with a mix of care and support needs.

Although the original intention of the Waimarino Rest Home Trust was to establish a rest home in the Waimarino (based around the small towns of Ohakune & Raetihi), changes in government policy, such as the development of the Positive Ageing strategy and its focus on ageing in place, and the removal of capital funding for rest home establishment, made this impracticable. The decision to consider the concept of the social village was made after the involvement of Presbyterian Support. Community and Council support was secured through on-going consultation and communication. All sectors of the Waimarino community were involved in the planning phases, including the DHB, local iwi and community, national-level care providers and the local council.

As a result, the village has the support of, and is reflective of the Waimarino community. Based on a complex of 16 flats formerly managed by the local council, occupancy, which had seldom exceeded 50%, has increased to 80%. The ethnic mix more closely matches the general population. There are currently six Pakeha and eight Maori tenants, who are living together with no negative feedback. Residents have different levels of dependency/independence, with more able people keeping an 'eye out' for the less able.

A new building, presently under construction, will incorporate a community centre. This will function as a 'social hub' and provide the base for services providing care for residents both of the Village and of the wider communities of Raetihi and Ohakune, thus people and activity will be drawn into the Elder & Care Village. The community centre will include:

- a common room, for the use of residents and non-residents
- a quiet room for the use of all: staff, treatment of residents and non-residents
- an office space and nurses' station
- a bathroom area
- a full kitchen
- laundry
- monitoring station of all 20 units on an as needs basis
- covered walkways from the central complex to outlying and existing units.

The building will also contain four self-contained studio units to provide accommodation for 'less independent elders' who require 'greater care, monitoring supervision and support'.

The vision for the Elder & Care Village is that it will allow the district's elders to remain safely in the community in an environment where they will be cared for, where they will be stimulated, and where they will be able to maintain social contacts they have established through living and working in the district. The village combines housing and care needs, and provides a model for 'ageing in place' in more remote communities.

## **Self-contained retirement communities**

Different models of tenure and different levels of care and support are found internationally. This model is similar to retirement villages as they are known in New Zealand and overseas. The examples presented illustrate special features or are aimed at lower income older people.

### *Hartrigg Oaks, York, England*

Hartrigg Oaks, established by the Joseph Rowntree Housing Trust (JRHT), and opened in 1998, was the first Continuing Care Retirement Community to be built in Britain. It is a campus style development on a 21 acre site. There are 152 bungalows built to Lifetime Homes specifications spread around a central building which contains a 41 bed care home and extensive communal facilities. The core buildings include:

- Restaurant and café
- Lounges

- Library
- Gymnasium and swimming pool
- Meeting rooms and activity rooms, studio, craft facilities
- Reception area and office
- Central control alarm and video monitoring
- Shop
- Hairdressers
- Child care centre.

Hartrigg Oaks was built on a greenfield site at the edge of the garden village of New Earswick, which consists mainly of social housing also managed by JRHT. It was intended that Hartrigg Oaks would become part of the wider community of New Earswick. While a small number of Hartrigg Oaks residents have become involved in various activities in the village, and the while Hartrigg Oaks has also provided some employment opportunities for residents of New Earswick, the two communities remain quite separate, in the eyes of both the Hartrigg Oaks and New Earswick residents (Croucher et al 2003). Problems of community safety and anti-social behaviour in New Earswick and expectations of the older community were regarded as obstacles to integration by residents of both villages, when interviewed in 2002.

Hartrigg Oaks is an independent non-profit-making community, wholly funded through JRHT and the contributions made by residents. Residents have a variety of payment options both for their residence fee and for the community fee, which covers care and support as well as property maintenance. One option is based on an insurance principle: - payment of a standard community fee, related to one's age on moving in, entitles residents to whatever level of care they need over time. However, Croucher et al (2003) note that costs to residents are substantial and, in its current form, the costs of living in Hartrigg Oaks mean this option is clearly not accessible to most people in the UK.

Despite the cost, Croucher et al (2003) note that there are features of Hartrigg Oaks that can be applied to other developments for older people, such as the high space standards and lifetime homes features, the amenities and range of care services available, and the operating ethos of Hartrigg Oaks with its emphasis on enabling and supporting independence.

### *Assisted living retirement villages in Australia*

In Australia, two companies have taken a lead in providing affordable assisted-living rental accommodation for older people. **SunnyCove** opened its first village in 2002, and has already twice won the Urban Development Institute Award, sponsored by the Queensland Government's Department of Housing, for Innovations in Affordable Housing. SunnyCove has three villages in Queensland, with another five in various stages of development. It aims to provide 'affordable lifestyle rental accommodation for seniors nationally'. **Village Life** opened its first village in 1999, and has established fifty rental retirement villages throughout Australia.

Both set rentals related to the Australian age pension. SunnyCove advertises its rates at 85% of the full rate of the single aged pension and 85% of the full rental assistance rate, while Village Life advertises its at 85% of the standard single age pension, plus 100% of the rent assistance.

Residents receive three meals a day, usually served in a community dining room, although this varies from location to location. Bed linen and towels are provided on a weekly basis, and twenty-four hour on-site management provides security for residents. Both Village Life and SunnyCove select staff for their empathy and their competence in providing for the needs of older people, and pre-entry training is provided. Villages are sited close to 'preferred neighbourhoods' for seniors, with access to public transport, shopping, entertainment, and health care facilities. Units are designed so that care and support services can easily be delivered to residents requiring them.

Units are owned by investors, who may or may not be residents. Village Life company information claims that a senior is 'financially advantaged' renting a Village Life unit and investing funds as opposed to purchasing a retirement village unit.<sup>21</sup> Standard unit designs and processes mean that both approval and construction processes can be 'fast-tracked'.

Village Life stress that the rental village sector is a new and distinct from that of aged care and retirement villages, and therefore that they are not bound by the requirements imposed on either sector. In contrast, SunnyCove Management was recently accepted as a member of Aged Care Queensland Incorporated, which is affiliated with both Aged and Community Services Australia and with the Retirement Villages Association of Australia.

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<sup>21</sup> <http://www.villagelife.com.au/pdfs/131290.pdf> accessed 24 May 04.

### *Summerset Retirement Villages, New Zealand*

Summerset began business in 1994, with the establishment of a 24-bed rest home facility in Levin, which is now part of the rest home and village operated by the Summerset Group in Levin. There are now seven retirement villages in various parts of the lower North Island.<sup>22</sup> Together they house 821 residents with an average age of 81. Three quarters of the residents are female, and one-quarter male. Villages have a mixture of two-bedroom villas, one-bedroom apartments, serviced apartments and rest home accommodation. Most Summerset villages also have rest home and continuing care.

The Summerset Group recognises that low-income older people cannot afford to live in many retirement villages. However, their philosophy is based on the belief that older New Zealanders should have access to a 'high standard of lifestyle in a safe, secure and enjoyable environment at an affordable cost' (Summerset Management Group 2004), and the business aims for a middle-income market. The business recognises that extending this type of accommodation into the lower income sector will require government support.

## **Information services**

In order for older people to be aware of their options, and to access appropriate services, providers must ensure that information about their services is disseminated effectively. The British Government's desire for further development of Home Improvement Agencies (whose role includes ensuring that older people have access to information about services and sources of finance, etc.) and disquiet at their low profile has already been discussed (HIAs, see page 81).

Clearinghouses with a role in disseminating information to older people, their advocates and service providers, are reviewed in this section.

### *Clearinghouse for information on home modification and maintenance services*

A review of the New South Wales Home Modification and Maintenance Services (Bridge and Flynn 2003) found significant knowledge gaps amongst contractors, service providers and occupational therapists. The review also found that while numerous design guidelines exist, they were typically contradictory, internally inconsistent and incomplete, thus limiting the ability of the sector to ensure quality or consistency.

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<sup>22</sup> An eighth site comprises a 25 bed high dependency residential unit.

As a result of the review, a web-based clearinghouse has been developed. The benefits, as understood by Home Modification and Maintenance (HMM) stakeholders, are:

- questions about practice and innovations can be raised and answered
- a wide variety of material can be shared through internet and intranet services
- gaps can be more quickly identified and targeted
- policy will be easier to access, evaluate and develop.

Specialist resources developed by the clearinghouse include:

- evidence based practice reviews, translated into consumer and industry fact sheets and checklists
- occasional research papers
- annotated bibliographic materials
- annotated web links
- newsletter with stories relevant to the sector.

The HMM Information Clearinghouse clearing house can be accessed at

<http://www.arch.usyd.edu.au/hmminfo.html>

A similar service is offered in the United States by the National Resource Center on Supportive Housing and Home Modification. Its website provides a National Directory of Home Modification Resources and access to research. This can be accessed at

<http://www.usc.edu/dept/gero/nrcshhm/>

### *Clearinghouse for information on shared housing*

The concept of homesharing was discussed earlier in this chapter (see page 86). Homeshare International originated in the USA and there are more programmes running there than in any other country. In the USA, the term 'homeshare' refers to the match-up programmes mandated by Homeshare International, and also to shared living arrangements on a group basis. The National Shared Housing Resource Center is a national clearinghouse for consumer inquiries about all shared housing programmes in the USA. It informs other allied organisations about shared housing, and maintains a national directory of shared housing programmes. It also provides technical assistance for beginning, marketing and maintaining shared housing programmes throughout that country. The clearinghouse can be accessed at

<http://www.nationalsharedhousing.org>

## Chapter 4. Looking to the Future

### Demographic Trends

Demographic projections depend on assumptions about fertility, mortality, and migration. In terms of projecting trends for the older population in the coming 50 years, mortality assumptions and, to a lesser degree, migration patterns are relevant.

The Statistics New Zealand medium-medium-medium projection to 2051 has been adopted here.<sup>23</sup> The medium migration assumptions are based on a long-term average net inflow of 5,000 per annum. Table 34 shows that this projection takes the New Zealand population to just over 4.5 million by 2021, and 4.8 million by 2051. The total population is expected to grow by 624,000 over the 20 years from 2001, and more than half of this total (331,000) will be people in the 65 plus age group. Furthermore, of the 925,000 added by the end of the 50 year period to 2051, over 80% (726,000) will be 65 or over, with more than a quarter (238,000) 85 and over. By 2051, there will be 1.18 million people aged 65 and over in New Zealand, representing an increase of 165% since 2001. At that stage, older people are expected to make up 26% of the New Zealand population of 4.63 million. Within the older population, it is the age group 85 and over which will have the highest growth rates. The projections indicate that the number of people aged 85 plus will increase six-fold between 2001 and 2051. This is important, given the higher levels of care required by very old people.

Such projections can be contentious. Migration assumptions in particular are closely dependent on relative economic performance. However, alternative assumptions of net migration inflows have only a small influence on total numbers in the older age groups. For example, a medium-medium-high scenario with average annual net migration inflows of 20,000 results in a total population of 5.8 million in 2051, (ie another million compared to the medium-medium-medium projection). This high migration scenario, however, estimates 1.35 million people aged 65 and over, compared to 1.22 million in the medium migration scenario. In other words, the high migration scenario adds only another 130,000 to the older population, but has a more significant impact on the remainder of the population (another 870,000 people under 65 years old).

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<sup>23</sup> That is: medium fertility, medium mortality and medium migration assumptions.

**Table 34 Population projection to 2021 and 2051 (medium, medium, medium )**

		All ages	65-74	75-84	85+	TOTAL 65+
<b>Population numbers (000s)</b>						
<i>Total</i>						
	2021	4505	441	239	113	792
	2051	4806	491	437	288	1217
<i>Maori</i>						
	2021	750	41	13	4	57
	2051	990	67	42	20	129
<i>Pacific</i>						
	2021	413	16	7	2	25
	2051	574	36	22	8	66
<b>Proportions (%)</b>						
<i>Maori as % of total popn</i>						
	2021	16.6	9.2	5.3	3.3	7.2
	2051	20.6	13.7	9.5	6.9	10.6
<i>Pacific People as % of total popn</i>						
	2021	9.2	3.7	2.8	1.8	3.2
	2051	11.9	7.4	5.0	2.8	5.4

## Trends by ethnicity

The ethnic composition of older New Zealanders will also change in the future. The number of Maori and Pacific people aged 65 plus will more than double between 2001 and 2021 and again between 2021 and 2051 (Table 34). The numerical increases will be significant.

However, older people will continue to represent a low proportion of these ethnic groups. Maori aged 65 plus will grow from 3% of all Maori in 2001 to 8% in 2021. Pacific people aged 65 plus will grow from 3% to 6% of the Pacific group. Over the same period, people in this age group will grow from representing 12% of the total population in 2001, to 18% in 2021.

The population 65 plus will remain predominantly Pakeha, with Maori, Pacific people and Asians combined expected to represent only 17% in 2021. This will, however, have risen from a combined total of 9% in 2001. Thus the older population will become more diverse in its ethnic composition.

## Housing tenure in the future

Assuming that there will be no changes in tenure patterns, estimates of the housing situation of older people in 2021 are listed in Table 35 (page 118).

- In 2021, over 713,700 older people will be in private dwellings and nearly 78,300 in non-private dwellings (including residential care). Within the private dwellings category, over 582,000 are projected to be homeowners, with 17,300 renting from a territorial local authority (TLA), 23,000 renting from Housing New Zealand Corporation (HNZC) and 91,400 renting from private landlords. Of the 78,300 in non-private dwellings, 50,800 would be in residential care.
- Over the 20 years between 2001 and 2021, these numbers signal an additional 61,400 older people requiring rental accommodation, including nearly 10,600 more from HNZC and 8,000 more from TLAs. This represents a doubling of 2001 numbers in these categories.
- Numbers of older homeowners will increase by around 90%, to give an estimate of an additional 271,700 people.
- Re-emphasising the assumption of no change in tenure patterns, these projections suggest an additional 26,200 older people in residential care by 2021. This is an increase of 106% in this category. A large proportion of this increase will be in the 85 plus category, with this age group accounting for 17,400 of the increased numbers.
- The estimates for 2051 suggest a five-fold increase in the 2001 numbers.
- In 2051, nearly 1.06 million older people will live in private dwellings and 157,800 in non-private dwellings (112,400 in residential care). Nearly 860,000 are projected to be homeowners, with 27,500 renting from a TLA, 33,300 from HNZC and 138,000 from private landlords.
- This projection is consistent with an additional 128,900 older people requiring rental accommodation over the coming 50 years - nearly 21,000 more from HNZC, 18,200 from TLAs and 89,700 from the private rental market.

- There will be an addition of over half a million older homeowners.
- The projection sees an additional 87,800 older people in residential care over the 2001-2051 period. Nearly three-quarters (64,400 people or 73%) of the increase will be people in the 85 plus age group. Again, this assumes no change in the current proportions of people living in different types of housing and housing tenure.

## **Household tenure by ethnicity projections**

Projections for older Maori and Pacific people are presented in Table 36 and Table 37. These have also been generated on the assumption of no change in tenure patterns.

Changes for Maori between 2001 and 2021 -

- On this estimate, by 2021, the number of Maori aged 65 and over will have increased by 41,000. Over 60% of these will be homeowners, but 7,700 will rent from private landlords, 3,600 from HNZN and 1,700 from TLAs.
- There will be a growth of almost 1,100 for older Maori in residential care. These numbers indicate an expansion of the order of 250% on 2001 levels.
- In line with continuing ethnic disparities in life expectancy, only a very small proportion of the increase in older Maori occurs in the 85 plus age group. This is in contrast to the picture for the whole population, in which 27% of growth in the 65 plus population between 2001 and 2021 is attributable to increased numbers of people aged 85 and over.

Changes 2001 to 2051 –

- Between 2001 and 2051 there will be an increase of 113,000 older Maori. There is an estimated increase of 4,600 renting from TLAs, 10,000 from HNZN and 21,000 from private landlords. There will be an increase of nearly 3,000 Maori in residential care, most of them aged 85 plus.
- Population projections for Pacific people are characterised by small numbers, especially

in the 85 and over age group. However, this population is expected to increase significantly in percentage terms. There will be an estimated addition of 18,100 older Pacific people between 2001-2021 period, which represents a 265% increase.

Changes for Pacific people 2001 to 2021 -

- Assuming unchanged tenure patterns, by 2021, there will be a further 5,700 older Pacific people who are HNZN tenants, as well as an additional 3,100 renting from private landlords.
- Although there are currently few Pacific people in the over 85 age group, by 2021 there will be a six-fold increase in this group.
- The extra 650 Pacific people projected to be in residential care means a tripling of numbers in this category.

Looking further out, between 2001 and 2051, the number of Pacific people aged 65 and over is expected to increase by eight-and-a-half fold. The two largest tenure groups, homeownership and renting from HNZN, are expected to increase by 26,700 and 17,300, respectively.

**Table 35 A no change projection of housing tenure for older people**

	OWN HOUSE	RENTING			TOTAL PD	Retirement Home (Cared)	OTHER NPD	TOTAL NPD	TOTAL
		TLA	HNZ	OTHER					
<b>2021</b>									
65+	582,064	17,296	22,924	91,417	713,701	50,784	27,515	78,299	792,000
85+	60,203	2,624	2,046	11,400	76,273	29,996	6,355	36,352	112,625
<b>2051</b>									
65+	859,898	27,479	33,329	138,373	1,059,078	112,390	45,404	157,794	1,216,872
85+	155,786	6,752	5,270	29,446	197,254	77,009	16,368	93,377	290,631
<b>2021 increase from 2001</b>									
65+	271,768	8,014	10,570	42,793	333,145	26,175	13,319	39,494	372,639
85+	36,248	1,541	1,206	6,807	45,802	17,417	3,745	21,163	66,965
<b>2051 increase from 2001</b>									
65+	549,602	18,197	20,975	89,749	678,522	87,781	31,208	118,989	797,511
85+	131,831	5,669	4,430	24,853	166,783	64,430	13,758	78,188	244,971

**Table 36 A no change projection of housing tenure for older Maori**

	OWN HOUSE	RENTING			TOTAL PD	Retirement Home (Cared)	OTHER NPD	TOTAL NPD	TOTAL
		TLA	HNZ	OTHER					
<b>2021</b>									
65+	35,924	2,334	5,043	10,622	53,923	1,487	1,591	3,077	57,000
85+	1,967	105	226	647	2,945	542	263	805	3,750
<b>2051</b>									
65+	81,118	5,272	11,370	23,978	121,738	3,353	3,596	6,948	128,686
85+	10,444	560	1,212	3,450	15,666	2,891	1,399	4,290	19,956
<b>2021 increase from 2001</b>									
65+	25,907	1,683	3,639	7,661	38,890	1,073	1,147	2,219	41,109
85+	1,631	87	187	536	2,441	449	218	667	3,108
<b>2051 increase from 2001</b>									
65+	71,101	4,621	9,966	21,017	106,705	2,939	3,152	6,090	112,795
85+	10,108	542	1,173	3,339	15,162	2,798	1,354	4,152	19,314

**Table 37 A no change projection of housing tenure for older Pacific people**

	OWN HOUSE	RENTING			TOTAL PD	Retirement Home (Cared)	OTHER NPD	TOTAL NPD	TOTAL
		TLA	HNZ	OTHER					
<b>2021</b>									
65+	10,945	588	7,739	4,287	23,558	854	588	1,442	25,000
85+	808	30	509	239	1,586	359	120	479	2,065
<b>2051</b>									
65+	29,818	1,965	19,301	11,269	62,352	1,965	1,676	3,641	65,993
85+	3,027	245	1,800	1,227	6,298	1,227	573	1,800	8,098
<b>2021 increase from 2001</b>									
65+	7,849	384	5,735	3,117	17,084	650	414	1,064	18,148
85+	697	21	443	194	1,355	314	99	413	1,768
<b>2051 increase from 2001</b>									
65+	26,722	1,761	17,297	10,099	55,878	1,761	1,502	3,263	59,141
85+	2,916	236	1,734	1,182	6,067	1,182	552	1,734	7,801

## Household tenure by income projections

Groups of older people who are likely to have their accommodation options restricted are those with low income and low asset levels and those who have not achieved homeownership (Chapter 1). A *no change* housing tenure projection has been used to produce Table 38 and Table 39.

**Table 38: Housing tenure by income, 2021 (*no change* projection)**

	All private dwellings	Own home	Rent from TLA	Rent from HNZ	Rent from other
<b>65+</b>					
<b>ALL ETHNIC GROUPS</b>					
<b>Total</b>					
low income	129,704	90,829	10,788	6,980	21,107
moderate income	284,716	243,988	3,253	6,601	30,874
higher income	198,595	174,763	311	2,800	20,720
income not stated	100,687	72,485	2,944	6,543	18,715
<b>TOTAL</b>	<b>713,701</b>	<b>582,064</b>	<b>17,296</b>	<b>22,924</b>	<b>91,417</b>

The total number of low-income people, aged 65 plus, is expected to increase from 73,200 to 130,000 over the 2001-2021 period. Table 38 records another 100,000 in the 'income not stated' category (based on 2001 proportions) some of whom would also probably fall into the low-income category.

Between 2001 and 2021 the number of older homeowners in the low-income category will grow from 49,100 to 91,000, on this estimate. Numbers of the low-income TLA tenants will also grow from 5,800 in 2001 to 10,800 in 2021.

Projecting income distribution to 2051 is likely to be very imprecise but, for illustrative purposes, information is presented in Table 39. This suggests that there will then be 134,000 low-income older people who are homeowners, 17,100 who are TLA tenants, 10,000 who are HNZC tenants and 32,000 who will be renting privately.

If income and tenure patterns remain unchanged, then these projected numbers clearly indicate a significant challenge to TLAs and HNZC in terms of the quantum of housing required for low-income older people. They also suggest an important role will continue to be played by the private sector rental market. These projections do not take into account recent declines in the rate of home ownership. An alternative scenario, illustrating what might occur if homeownership continues to fall, is part of the cost-benefit exploration of future options in the next section.

**Table 39 Housing tenure by income, 2051 (no change projection)**

	All private dwellings	Own home	Rent from TLA	Rent from HNZ	Rent from other
<b>65+</b>					
<b><u>ALL ETHNIC GROUPS</u></b>					
<b>Total</b>					
low income	193,387	134,040	17,156	10,155	32,035
moderate income	421,918	360,501	5,137	9,591	46,688
higher income	294,136	258,278	489	4,070	31,299
income not stated	149,637	107,078	4,696	9,512	28,350
<b>TOTAL</b>	<b>1,059,078</b>	<b>859,898</b>	<b>27,479</b>	<b>33,329</b>	<b>138,373</b>

## Scenario costs and benefits for the future

As noted in the previous section, under a *no change* assumption an additional 61,400 older people would require rental accommodation over the 2001-2021 period. However, over the decade from 1991 to 2001, home ownership rates (across all age groups) declined from 74% to 68%. As noted in DTZ New Zealand (2004), the falls were significantly greater for the younger age cohorts, that is, tomorrow's older people. As against the overall decline of 6 percentage points, there was a 9 percentage point fall for the 40-44 age group - those that will be nearing age 65 in 2021.

To set against the *no change* assumptions is a scenario that takes trends in home ownership rates into account and reduces the proportion of older people that reside in their own home by 5 percentage points by 2021. The consequent changes in each tenure category between 2001 and 2021 are listed in Table 40. These numbers imply a reduction in the number of older

people residing in their own home of the order of 39,600 (when compared to the no change scenario). Allocating these into rental categories implies *another* 5,200 TLA tenants, 6,900 HNZN tenants and 27,500 seeking places in the private sector rental market.

In a further scenario, we explore the outcome of a reduction in the proportion of older people entering residential care. As noted in Chapter 2, people are entering residential care at higher levels of disability and at older ages than in the past. In this scenario, we assume the number of older people in residential care in 2021 to be 5% lower than in the *no change* scenario.

Table 40 shows that this movement implies approximately 2,500 fewer people in residential care and proportionately more across the own home and renting categories.

As noted earlier, the cost-benefit implications of the accommodation options are potentially swamped by the:

- effect from the individual's perspective on *intangibles*, for example, independence, security, social isolation and proximity to care services.
- effect from the government's perspective on combined DSS and personal health expenditure.

Intangible impacts are difficult to measure but their importance may be larger than measurable financial impacts from the individual's perspective. Intangible impacts are (arguably) more likely to result in greater net benefit (or less net cost) when the available accommodation options are closely aligned to individual needs. This argues for an approach in which agencies work together to assist older people to remain in appropriately upgraded or modified private dwellings.

**Table 40 Scenario tenure projections to 2021 for all older people**

Scenario	Own house	Renting			Residential care
		TLA	HNZ	Other	
<b>Projected number in 2021</b>					
No change in tenure pattern	582,064	17,296	22,924	91,417	50,784
Reduced rate of home ownership	542,464	22,532	29,780	118,924	50,784
Reduced rate of residential care	584,135	17,358	23,006	91,742	48,244
<b>Projected increase between from 2001 to 2021</b>					
No change in tenure pattern	271,768	8,014	10,570	42,793	26,175
Reduced rate of home ownership	232,168	13,250	17,426	70,300	26,175
Reduced rate of residential care	273,839	8,076	10,652	43,118	23,635

## Government expenditure scenarios

In this section, indicative expenditure figures for 2021 and for 2051 are expressed in real 2002/03-dollar terms. Future price inflation will add proportionately extra to all these figures. Using 2002/03 dollar terms, however, gives an indication of the real resource requirements needed to meet the older population's health needs.

In terms of government health expenditure, assuming: no change in policy settings, the incidence of disability, no difference between renting and homeownership, suggests that:

- DSS provision for older people rises to nearly \$1.8bn by 2021 and to \$4.1bn by 2051.
- Personal health expenditure for older people rises to \$2.8bn by 2021 and to \$4.9bn by 2051.

This scenario can be tested for sensitivity to some of the key assumptions. Amongst the key assumptions in projecting the impact on government health expenditure is the association

between housing tenure and health status. Indicative impacts on government spending as a result of some alternative assumptions for the projections are listed in Table 41.

**Table 41 Indicative scenarios for 2021 Government health expenditure**

<b>Scenario assumptions</b>	<b>DSS \$m</b>	<b>Personal Health \$m</b>	<b>Total \$m</b>	<b>Difference from no change base \$m</b>
<b>No change in tenure patterns</b>	<b>1,786</b>	<b>2,819</b>	<b>4,605</b>	<b>na</b>
All renters have 5% higher needs	1,796	2,843	4,639	34
Private renters only have 5% higher needs	1,792	2,835	4,628	23
<b>Reduced rate of home ownership</b>	<b>1,793</b>	<b>2,827</b>	<b>4,620</b>	<b>15</b>
All renters have 5% higher needs	1,806	2,858	4,664	59
Private renters only have 5% higher needs	1,802	2,848	4,650	45
<b>Reduced rate of residential care</b>	<b>1,751</b>	<b>2,816</b>	<b>4,567</b>	<b>-37</b>
All renters have 5% higher needs	1,761	2,841	4,601	-3
Private renters only have 5% higher needs	1,758	2,833	4,590	-14

### **No change in tenure patterns**

We begin by retaining the assumption of no change in tenure patterns, but specify a scenario where renters have 5% higher health needs, including care and support expenditure. This assumption reflects a situation where rental property is not maintained sufficiently or to the same level as ownership properties, and that consequent issues of dampness, mould and insufficient heating have a negative effect on health. Such an assumption potentially increases the total of DSS and personal health expenditure by the order of \$34m.

However, property and maintenance standards may be higher in public sector housing. If the increased health needs are assumed to apply to private sector renters only, then additional required spending will be \$23m.

### **Reduced home ownership rates**

A reduction in home ownership rates is estimated to produce a \$15m impact on required government spending because of the shift to renting. This arises because the renting

population has a higher proportion of women than other tenure categories. Application of existing gender-specific per-capita spending data, with higher requirements for older women than for older men, results in this effect.

Linking reduced rates of homeownership with higher health demands from renters creates a much larger impact of \$59m, which will be reduced using the assumption about differing housing quality between public and private sector housing. However, the size of this impact is much larger than any of the alternatives under the *no change* in tenure patterns assumption.

These numbers emphasise the dual influence of housing quality and housing tenure.

- while the projections suggest that the majority of older people will still reside in ownership properties in 2021 (well over half a million in all of the scenarios discussed), a small change in the rate of homeownership (continuing recent trends) can make a noticeable impact on indicative health expenditure projections.
- small differences in the quality of housing can also make a noticeable impact from the government's fiscal perspective. To this must be added the intangible aspects from the individual's perspective and wider community wellbeing.

## **Reduced residential care rates**

The key element for this scenario is the projected increase of the population aged 85 plus. This age group represents by far the largest proportion of those in residential care and, consequently, accounts for the largest proportion of DSS expenditure.

Under the *no change in tenure* assumption, the number of people aged 65 and over in residential care is projected to approximately double. However, numbers in the 85 plus group will more than double and, given higher age-specific per-capita health service needs for this group, total expenditure more than doubles.

The alternative scenario reduces the number of older people in residential care by 5% (compared to the *no change* scenario), which corresponds to approximately 2,500 persons. Assuming these people have similar health needs across housing tenure groups provides a net benefit on government health expenditure of the order of \$37m (or approximately \$14,500 per

annum per person). This benefit is reduced using the assumption that rental property is inherently inferior to ownership housing.

As before, these numbers capture only the government fiscal benefit, before allowing for benefits accruing to individuals and/or communities in terms of increased independence and other dimensions.

The sensitivity of these scenario outcomes to the assumptions which are adopted is even more pronounced when the projections are expanded to 2051. Here the key element is the expansion (roughly six-fold) in the 85 plus age group. Even though there are projected to be over 290,000 in this age group in 2051, assuming a shift of even 5,000 out of residential care could make a noticeable impact on the DSS provision required (retaining assumptions on disability incidence by age, and housing tenure differences). For example, the reduction of 5,000 in 2051, representing - under no change assumptions - about 4% of those in residential care, and their location in private dwellings results in an overall reduction in required DSS and personal health expenditure of the order of \$87m.

## Implications

These are illustrative scenarios and not forecasts but they demonstrate the magnitude of potential benefits if older people remain longer in private dwellings as opposed to residential care, especially people 85 or older. The net benefit on government health expenditure of the order of \$14,500 per person per annum in this age group. On fiscal opportunity cost-benefit criteria, this is the *additional* amount that could be spent to facilitate/support older people to remain in private dwellings, including care and support services in the home as well as house modifications and upgrading. Furthermore, this amount would be additional to other support provision (such as Accommodation Supplement and home care funding) which is already allocated for older people in private dwellings. Where such spending is successful in reducing the need for residential care, then any wider benefits accruing to individuals and/or communities would further strengthen the argument. On the other hand, where such spending is not successful, then higher residential care costs would be incurred.

On fiscal cost-benefit criteria alone, policy and/or housing options to support older people to remain living in the community should be pursued, and expanding/establishing options for people in the 85 plus age group offer the greatest potential benefit. Elsewhere in this report (Chapters 5 and 6) we explore options for the re-direction of expenditure to maximise the

possibility of a ‘successful’ outcome – in terms of net fiscal, individual and wider community benefit. This concerns not only an examination of current and potential accommodation options, but also questions about the roles to be played by central and local government agencies (including DHBs) and organisations in the voluntary, community and private sectors.

## Home modifications and maintenance

Requirements for home modifications/maintenance for older people are central, given the high proportion of older people who live, and will continue to live in community settings (in owned or rented accommodation) and higher levels of disability and health care needs among the older population. References to the need for home modification and maintenance have been made throughout preceding and subsequent chapters. This section explores the order of magnitude of the costs likely to be involved.

The 1999 *New Zealand House Condition Survey* conducted for BRANZ (Clark 2000) noted the general lack of maintenance in the New Zealand housing stock. As noted earlier, it was estimated that, on average and in 1999 terms, \$4,000 per house was needed to repair ‘poor to serious’ conditions, while average maintenance expenditure totalled only \$1,500. The most comprehensive estimate was \$6,900 per house, while repairing only the ‘serious’ conditions required \$1,400.

Some of the requirements are not applicable to all houses,<sup>24</sup> but many of the components are clearly relevant to all homeowners. Average costs to repair bathroom and kitchen conditions, both linings and fittings, was estimated at \$415 and \$469, respectively. In terms of modifications/renovations Rawlinson’s *New Zealand Construction Handbook* (2001) lists the following installed costs (excluding GST):

- shower bases ranging from \$300 (stainless steel) up to \$750 for the larger sizes
- full shower enclosures begin in the vicinity of \$1,700
- internal handrails are of the order of \$55 to \$70 per metre.

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<sup>24</sup> For example, the largest (most expensive) component found to require remedying was ‘sub-floor ventilation for a house with a continuous concrete perimeter foundation wall (estimated at between \$800 and \$2400 for a standard house).

External ramps and/or landscaping will vary widely given the nature of the terrain and extent of work required.

When costs of this order are taken into account, annual maintenance requirements for homeowners clearly represent a potentially large financial commitment for older people on limited incomes. Where it can be shown that poorly maintained housing is impacting on the health status of individuals, there is a *prima facie* ‘public good’ argument for government to assist in the maintenance and renovation. Such intervention could lead to health savings in the order of those discussed.

Clearly, the issue of maintenance and upgrading will be assessed by the individual against the alternative of ‘trading down’ (depending on potential selling price) and other options, mentioned elsewhere in this report, including the option of equity release. Preferences concerning family, lifestyle, location and proximity to services will also be influential in these choices.

## Conclusions

While both economic and demographic projections are fraught with difficulty, assuming the continuation of existing behaviour provides a ‘reference point’, to identify potential issues or constraints. Furthermore, generating scenarios around the *no change* projection tests the sensitivity of the outcome to the key ‘continuation of existing behaviour’ assumptions.

The key points that arise:

- With no change in rates of homeownership the next 20 years would see an increase of approximately 16,500 older people requiring rental accommodation from the ‘public’ (TLA or HNZC) sector. On the basis of current proportions of one-person households, this equates to around 735 new housing units every year.
- Currently interest on the part of TLAs to increase their role in social housing is low. But HNZC plans to increase its national housing stock by an average of 1000 per year in the coming three years (with over 80% expected in Auckland).

- Noting that HNZC increases are for its total housing stock (not just for older people) these numbers indicate a potential shortfall in the number of homes available in the public sector. In this light there are three options:
  - a supply-side response: acquire more houses to add to the public housing stock to cope with the additional demand
  - a demand-side response: attempt to change/modify behaviour to alleviate the shortfall
  - a combination of both of the above.

### **Supply-side response**

The public sector housing stock needs to be increased. The issue is not just the number of homes, but equally importantly, the quality and appropriateness of the homes for older people. Furthermore, it is acknowledged that existing housing stock is in need of significant repair, upgrading and modifications. Clearly, just as the composition of the population is changing, the composition of New Zealand's housing stock needs to be modified to better suit the population's needs.

Over 25,000 units of existing HNZC housing stock were built prior to 1960. Modernisation is being undertaken over the long-term. In each of the last two years 440 houses have been modernised at a cost of \$40,000-\$60,000 per unit. The new public sector homes required for older people could be obtained through a combination of new purchases and modernisation/upgrades of existing stock. Rawlinsons (2001) indicates costs ranging from \$66,250 to \$83,750 per unit for 'one-two storey self-care units, elderly persons home, with communal lounge heating services, no air-conditioning, medium standard finish.' Taking an average of \$70,000, the 735 new public sector homes required for older people translates to an annual cost in the vicinity of \$50m.

### **Demand-side response**

Modifying behaviour to alleviate housing shortfalls involves a combination of initiatives. Consistent with ageing in place, assistance with modifications will enable older people to remain for longer in their own homes. This should be seen as a long-term means to support and increase rates of homeownership and thereby reduce demands made on public sector

supply. In this context, the provision of care and support services is also relevant, through DHBs and associated providers.

Partnerships with other housing providers in the third sector also have a role to play in alleviating the shortfall in appropriate housing for older people, using models such as the existing and proposed social village / shared accommodation options, described in Chapter 3.

## **Risks**

Sensitivity tests highlight the importance of the *no change* assumption. Given recent declines in homeownership rates and affordability, the assumption of no change in homeownership levels could be seen as somewhat optimistic. If the scenario includes a continuation of recent drops in home ownership, then requirements for public sector rental accommodation for older people will be increased. In addition, the *no change* outcomes sees a further 43,000 older people entering the private rental market. Again, the issue of quality of the housing stock and its appropriateness for older people arises. This prospect cannot be viewed with optimism, certainly for low-income groups, unless there are measures to ensure New Zealand housing stock is modified to suit the changing composition of the New Zealand population.

## **Cost benefit summary**

At the national level, the numbers indicate a combination of programs (and sectors) are required to alleviate the projected shortfall in suitable accommodation for older people.

Cost-benefit analysis indicates that preferred options:

- from the perspective of the individual will be determined through a combination of impacts on ‘intangibles’ such as independence, proximity to care and support needs and social interaction, as well as security. However, options will be limited for those without access to lump-sum capital (existing tenants) or with limited access to such capital (homeowners with poorly-maintained and/or low value houses).
- from the perspective of the government, the impact on care and support needs is the largest factor. Here the link between housing conditions and health status is critical, especially as it relates to the amount of residential care which is required, and provides the justification for investments ensuring appropriate quality accommodation for older people.

The importance of intangibles in overall preferences indicates that a best or 'preferred option' cannot, and should not, be pre-ordained. The role of government (with the dual aims of minimising net fiscal costs and improving overall wellbeing) is to ensure that there is a co-ordinated approach between housing providers (Housing New Zealand Corporation, local authorities, voluntary organisations, private sector) and care and support and health providers (DHBs, private and voluntary sector). This co-ordination necessarily requires cross-sector strategies as well as leadership, with a reduction in the 'silo' approach to funding and an ongoing increase in the 'whole of government' view to policy and associated determination of funding. Some of these issues are returned to in the following chapter.

## **Chapter 5. Issues for the Future**

The international examples presented in Chapter 3 provide useful ideas and concepts when looking to the future in New Zealand and considering what models of housing for older people might be applicable. In addition, these examples throw up a range of cross-cutting issues, relating to the processes of evaluating, creating and managing the various housing options. These are examined in this chapter, as a precursor to the final chapter, which highlights the implications for the future in an ageing New Zealand.

### **Requirements to support Ageing in Place**

Approaches to housing for older people, both in New Zealand and overseas, reinforce the emphasis on ‘ageing in place’, that is, remaining living in the community, with some level of independence, rather than in residential care. This emphasis is being applied, as the examples from Denmark and France (Chapter 3) show, even for older people with significant levels of dependence. The ability to age in place also emerges as a strong preference on the part of older people themselves. However, the previous analysis also suggests that a range of measures is needed to support ageing in place. These include ensuring appropriate forms and quality of housing, whether existing housing or specialised developments, and the availability of required support and care services.

### **Adaptations, maintenance and renovations**

Safe, warm, affordable housing can mean the difference for many older people between staying in the community or moving into residential care. .... If we are to fully adopt an ‘ageing in place’ model, we will need to ensure that (home) modification budgets are sufficient. There needs to be more work put into thinking about how to provide early interventions, such as hand rails, rather than only being able to handle the ‘urgent’ cases. (Canterbury DHB submission to the study)

The OECD sees considerable economic merit in supporting home adaptation and upgrading.

Improvements of the existing stock are a more effective use of the housing budget than special purpose housing construction, which requires large outlays over longer periods of time. (OECD 2003 p202)

There is evidence of unmet need in this area in New Zealand. The 2001 Household Disability Survey included questions on home modifications. The results are forthcoming, in a report by the Ministry of Health and show that there is considerable unmet need. The most common indoor modifications are grab or hand rails, followed by wet-area showers and easy-to-get-to toilets. Outdoors, handrails at steps or doorways, easily accessible driveways, ramps and street level entrances are the main changes. Only a minority of people with disability are able to access government funding (from the Ministry of Health, Work and Income, or ACC) to pay or partly pay for these alterations. This may be because of funding limitations, but also through lack of information to potential clients, and service coordination. HNZA case managers can assist with the process of adapting homes, public and private, and finding suitable or adaptable homes to meet the needs of people with physical disabilities.

The cost of home maintenance and alterations for older homeowners on middle or low incomes, and the fear of falling housing quality if necessary work is not done, have prompted assistance schemes in some countries, using suspensory loans, grants, claims against the estate or home equity release schemes. In Britain, government-funded Home Improvement Agencies help older people through the process of major adaptation, renovation and maintenance work (Chapter 3); Canada has property tax relief and home renovation grants and Japan offers lower loan rates for housing adaptations and improvements.

But cost may not be the only reason for neglecting home maintenance and adaptations. Many older people find them 'not worth it' or 'too much trouble', possibly leading to a run-down in the quality of the housing stock which they occupy. The OECD report also points out shortcomings of such schemes, which include the attitudes of the occupiers, that the renovations may not overcome all the deficiencies of the dwelling, and the sporadic nature of public sector support.

Older people in rental accommodation face additional problems with adaptations, renovations and maintenance.

One of the reasons why housing conditions may appear worse in the rental component of the stock arises from a lack of incentives for landlords to upgrade their properties

and asymmetric information flows between landlords and potential tenants regarding the physical state of properties. This particularly relates to how well insulated houses are and how secure the building envelope is during periods of rain or other bad weather (TPK submission to this study).

While homeowners benefit directly from home modifications that result in higher property values or lower household running costs, this is not generally the case for tenants. For example, insulation brings a warmer living environment and cheaper heating costs for the occupiers, but the cost of installing insulation is generally borne by owners. But, once installed, insulation becomes part of the building fabric so tenants may be less willing to pay extra for it. Incentives may be needed to encourage private landlords to undertake maintenance, upgrading and adaptation work.

## **The potential for equity release**

In Chapter 2 the point was made that many older homeowners have capital tied up in their homes, even though they are living on low incomes and have little opportunity for supplementing these through paid work. There is the potential for home equity capital to be released to supplement income post-retirement. This could also help improve the housing stock, by providing funds for older homeowners to renovate, adapt or repair their houses to provide a better quality of life and guard against the risks to health outlined in Chapter 1. Chapter 3 outlines current commercial equity release schemes in New Zealand. However, the scope can be drawn more widely. From the individual's point of view, there are several options for the disposition of housing wealth (Davey, 1995). Traditionally, home equity has been preserved for transference through the generations by inheritance, but, if homeowners wish to mobilise housing wealth, they have several other options.

While remaining in their homes, older people may derive extra income by taking in boarders or family members to live with them, either through informal arrangements or a shared housing scheme (as described in Chapter 3). While this type of arrangement reduces privacy and autonomy, when older people become less independent, and require some level of oversight, it can be an alternative to residential care.

A better return on housing investment could also be obtained if people intensify the use of their housing and/or residential sections. They may convert their large family homes into flats – especially if their household is reduced to one or two people – or build on, if their section is large

enough. Both options provide additional income but require capital for building work. Both may be used to provide on-site care and support, reducing the demand for residential care. The 'granny flat' concept is a similar approach, building on a relative's section (Chapters 2 and 3). These options tie in with town planning approaches which favour more intensive land-use in residential areas, but detailed regulations may be problematic. It is possible to envisage innovative concepts that allow older people not only to preserve their autonomy and personal space, but also to be near family members and other sources of care.

Commercial and sometimes public sector sponsored home equity release schemes exist in many countries. Generally current demand is low but the market has the potential to grow, given the high proportion of older people who are income poor and asset rich. The fact that homeownership is a highly favoured savings vehicle for New Zealanders also suggests that ways could usefully be found to mobilise this resource.

There are considerable constraints on acceptance and growth of commercial equity release schemes. These include the attitudes of potential clients towards inheritance, and on retaining assets for emergencies or to pay for long-term care. Fear of indebtedness, misgivings about government policy directions, and suspicion of the schemes themselves have emerged as serious barriers to the take-up of equity release schemes. However, the wish to bequeath, although it is still strong among people with direct descendants, need not be inconsistent with equity release. Many people believe that their children are better off than they are, and may indeed be middle-aged and well on the way towards their own retirement before they inherit. Most clients see equity release as a way of preserving their independence and avoiding being a burden on their children (Davey 1998b).

There are also constraints from the supply side. Potential providers may be wary of offering a new product which could be depicted as 'ripping off' older people or throwing them out of their homes. Working with older potential clients requires a labour-intensive approach with considerable explanation and reassurance, to build up a relationship of trust. Consumer protection is an important consideration, as has been shown in recent legislation on retirement villages. Equity release schemes also entail long-term commitment of capital and require an on-going cash flow to pay out the customers. The pay-back of capital could have to wait 20 years or more depending on the longevity of the clients, which may be hard to estimate. Central government policy, in the area of taxation, income and asset testing for residential care and retirement income, will affect providers as well as consumers.

Thus, the potential for mobilising housing wealth depends upon attitudes of individuals, families and society as a whole. Government action will provide incentives and disincentives, as policy objectives are pursued. Given a favourable environment and evidence of demand, the finance industry is likely to respond and produce vehicles to facilitate equity release. The New Zealand experience is summarised in Chapter 3 and recent developments described. Several contextual factors have contributed to this new start, for example:

- a rise in house prices
- longer life and better health in old age
- higher expectations of lifestyle in retirement
- concern about adequacy of state retirement income support
- encouragement to make private provision for retirement
- changing views on inheritance.

The same constraints, as outlined above, apply to these schemes. However, with careful marketing and consumer education, the entry into old age of a cohort more used to using credit as part of their financial management, and a decreased emphasis on inheritance, the prospects for equity release may be better now than they were ten to fifteen years ago.

### **Ongoing housing costs – rates**

Older homeowners, especially once they are mortgage-free, generally have lower housing costs than renters. However, local authority rates have been rising in recent years and can cause financial stress. The rates rebate scheme provides very limited relief, but is currently being reviewed (Chapter 2). As a new option, some local authorities are instituting schemes to defer rates payments by ‘rolling them up’ against the home equity. These include the Western Bay of Plenty District Council, Rodney, Far North, Thames-Coromandel and Gisborne who, from mid 2004, will offer residents over 65 an unlimited stay on their rates bills (NZ Herald April 26 2004). The rate debt will attract a floating interest rate and can be transferred to another house. Despite claims of considerable interest there has also been opposition to the schemes from Grey Power. Similar schemes exist in other countries.

### **Example of New Plymouth District Council**

NPDC is described as having steadfastly endeavoured to maintain its rates at a reasonable level, and they are reputedly the seventh lowest of all New Zealand local territorial authorities. The policy of limiting rate increases to inflation adjustments is made possible by the council's energy-related share dividends.

NPDC is currently 'looking constructively' at its rate structures, stimulated by a recent escalation in property values, particularly for homes with sea views and close to the foreshore. Councillors are aware that commensurate rate increases would place a considerable burden on homeowners, particularly older people on fixed incomes, who bought their homes when property values were relatively low.

At present any NPDC's ratepayer, irrespective of age, can seek to have their rate payments deferred should they find this necessary. Ratepayers can also choose to pay their rates in four instalments to spread the load throughout the year. While grappling with how to cushion the impact of the impending increase in rates, NPDC councillors are agreed that it is central government's role to maintain New Zealand Superannuation in relation to the cost of living.

## **Tenure options**

Both ownership and renting have inherent risks and benefits. Homeownership, especially once a mortgage has been discharged, represents an asset, but also a social status which appears to confer benefits well beyond the housing arena and is still a strong aspiration for most New Zealanders. This is illustrated in several studies, including the *Living Standards of Older New Zealanders* (Fergusson et al 2001), which shows that older people who enjoy the highest standard of living are homeowners who have paid off their mortgages. By contrast, older people who are still burdened with regular rent or mortgage repayments are over-represented among those with the lowest standard of living. Chapter 1 showed linkages between homeownership and better health levels. However, homeownership does not always protect people from poverty. Information presented in Chapter 2 showed large numbers of older homeowners in the low income groups, and recent calls from older homeowners for local body rate relief highlight a degree of financial hardship within this segment of the housing market. As pointed out in Chapter 1, the amount of equity in a home may not be sufficient to finance a move to supported housing.

Despite its many apparent benefits, there are concerns about declining levels of homeownership for most age groups in the New Zealand population (DTZ New Zealand 2004). Through HNZC, government is responding to this in various ways.

In addition to the recently introduced mortgage insurance scheme, piloted through Kiwibank, HNZC is exploring further options for innovative home ownership programmes. Potential models being assessed and considered for adoption include saving incentives, deposit assistance, shared equity and sweat-equity models. Planned consultation to develop the New Zealand Housing Strategy will include whether the government should be assisting people to buy their own homes (HNZC submission to study).

Nevertheless, the trends suggest that the demand for rental accommodation will grow among older people. Renting accommodation has advantages for this group. It relieves them of repair and maintenance costs, of the upkeep of grounds and of 'big-ticket' maintenance costs. Some types of public or voluntary sector housing include 'handyman', and support services in rental payments (as illustrated in Chapter 3). The disadvantages of renting include reduced security of tenure, especially in the private sector, less control over repairs, maintenance and adaptations, and the lack of an asset against which funds may be borrowed for special needs.

A range of actions to develop the private rental sector will be developed through the New Zealand Housing Strategy. Policy issues relating to private renting, identified by HNZC include:

- the sustainability of residential property investment
- the quality of property management
- insecurity of tenure
- the quality of services supporting landlords to provide good quality service and advising tenants and landlords of their rights and responsibilities
- the adequacy of the general regulatory environment.

A more proactive stance by HNZC might see the corporation attempting to manage housing rentals beyond their own holdings, possibly through leasing and upgrading from private landlords. The New Zealand private rental market is extremely fragmented, with a large number of small landlords who move in and out of the market, and who see their property as a passive investment and a source of capital gain, rather than as service provision.

A review of Residential Tenancies Act 1986, announced this year, will seek an appropriate balance between the needs and obligations of landlords and tenants and may improve security of tenure for renters.

The examples presented in Chapter 3 show that there is a much wider variety of tenure options than the well-known ownership or rental choices. Shared ownership or co-ownership is a possibility, which may allow access to housing by low-income older people, may reduce housing costs and ease the problems of maintenance. Some equity release schemes, for example home reversions, represent a type of shared ownership. In France, the *viager* concept allows older people to sell all or part of their houses to others on an individual basis, while retaining life tenancy.

An increasing proportion of older people are adopting a new form of housing tenure in making their houses over to family trusts. Fergusson et al (2001) show that 6.1% of people aged 65-74, 7.5% of those aged 75-84, and 2.5% of people 85 and over lived in homes owned by family trusts. This information is not included in the census, which groups private trusts together as owners, but the phenomenon and motives surrounding it need further exploration. Increasing use of trust ownership is likely to be related to asset protection, in relation to long-term care costs and possible business claims.

'Licence to occupy' arrangements in retirement villages, akin to long-term leases, are another new type of tenure, which lies between ownership and rental and has some of the advantages and disadvantages of both. 'License to occupy' appears similar to ownership, but has special considerations for resale and use of the equity, which at present are not well understood, and controversial. The Retirement Villages Act 2003 provides for better consumer involvement and protection with respect to this type of tenure.

Although not generally found in New Zealand, cooperative or co-housing provides accommodation for older people in other developed countries and its application to this country could usefully be explored. Different tenure modes are possible with co-housing, as discussed in Chapter 3. It differs from conventional housing in that it is often planned in cooperation with incoming residents. In Sweden co-operative models comprise about 18% of the housing market. They are often managed by nation-wide co-operative organisations, and many co-operatives have a high proportion of tenants aged 55 plus (OECD 2003, p117).

## **Desirable features in housing for older people**

The features of housing for older people, which are likely to enhance their wellbeing and health, apply to location, form and design. Some countries have special codes in this area, such as the Senior Citizen label in the Netherlands and Lifetime Homes in the United Kingdom (Chapter 3). The HNZC Development Guide incorporates universal design features, allowing the construction of properties that are suitable for a wider range of tenants. It is much cheaper to incorporate universal design features at the outset, than to provide later as modifications. Building regulations in the UK are under review, and full incorporation of Lifetime Homes standards is being considered. Universal design requirements could well be extended to all housing built using public funds in this country.

### **Structure, access and adaptation**

The physical effects of ageing need to be taken into account in the design and layout of housing (Cunniffe 1994). Older people may experience a decrease in anatomical size, reduced strength and coordination, diminished hearing and sight. Hence attention needs to be paid to the arrangement of living spaces and access, ease of movement around the house, working heights and surfaces, levels for storage, handles and power points, lighting, non-slip surfaces, ramps, hand-rails and the design of bathrooms (wet showers instead of baths, space for helpers) and kitchens (safety features). Access ramps and space to accommodate wheel chairs are important as, increasingly, are recharging sockets and space for mobility scooters. Low-maintenance construction is also beneficial for older people with limited incomes, who may also be unable to perform repairs.

New Zealand does not have comprehensive national surveys of housing conditions, comparable to the British data used by Tinker et al (2001) in *Eighty-five Not Out*. This is a gap in current tools for housing policy.

### **Heating and ventilation**

Older people are susceptible to cold but often do not feel temperature changes as readily as younger people. Their houses may not be adequately heated or ventilated. This may arise from lack of income to improve their housing or meet high energy costs; from the age of the housing they occupy or from occupant behaviour (for example, not reacting to cold, or not opening windows because of security concerns). However, inadequate heating and ventilation

can lead to dampness, cold and mould (Chapter 1) which are linked to high rates of respiratory illness and asthma, and other threats to physical and psychological wellbeing. In the UK, pensioners receive special winter fuel allowances. Energy efficiency schemes, aimed at the population as a whole may be of special assistance to older people, especially those living on low incomes, and have positive effects on health.

## **Safety and security**

A high proportion of accidents suffered by older people, requiring medical attention or hospital admission, occur within the home (Chapter 1) and may arise from housing design, for example falls on slippery surfaces. Even changing a light bulb can be a risky activity for the very old. Older people are especially susceptible to broken bones and, as many live alone, they may not receive prompt assistance if they are injured. Mandatory safety standards are a preventive measure and could help to mitigate the risks for older people. Home safety audits can produce appreciable reductions in accidents. The preventative home visits required by municipalities in Denmark have contributed to a marked reduction in the bed occupancy rate amongst people aged 75 plus (Wagner 2001) (see page 104 and footnote 18). They have been trialled in New Zealand (Cunniffe 1994) but cost may be a deterrent for older people.

Fire safety has received considerable attention in New Zealand. Older people with reduced mobility are especially vulnerable. A high proportion of houses now have smoke alarms, but these need to be maintained. The use of personal alarms and security lighting is widespread and also needs to be encouraged (Dwyer et al 2000). Personal security, over and above the possibility of accidents and sudden illness, is a concern for many older people. Older people's fear of victimisation outweighs the statistical risk but nevertheless this worry may impact negatively on their quality of life through, for example, fear of intrusion in their homes (Morris and Reilly 2003). Good locks and lighting can help to ease fears as can personal and house alarms.

As with the concept of universal design for housing, these safety and security issues apply to all ages. It is, however, important that over-regulation and over-zealous risk-avoidance policies, aimed at protecting older people, do not become problems in themselves through invasion of privacy, unreasonable costs and stifling of innovative initiatives.

## **Use of technology**

Technology has the potential to improve the quality of life of older people. This can range from 'low-tech' modifications, such as handrails and ramps, to 'smart houses' such as the one in the Hartrigg Oaks village in the UK (see Smart Homes, page 83 and Hartrigg Oaks page 108). Features include automatic heating and lighting controls, door opening, remote control taps, door entry system, central locking and electric windows. The European Commission is promoting TIDE (Technology Innovation for Disabled and Elderly people), a home service provision and house design code (OECD 2003, p175). In Scandinavia, inclusive design/universal design is well developed and ILSE (independent living solutions for everybody) is linked to lifelong education, to ensure that older people gain benefits from ICT (OECD 2003, p76).

However, there are also some negative aspects. New technology should not become a substitute for social care and social contact. It is hard to retro-fit in existing dwellings. The 'digital divide' means that older people may find technological innovations hard to accept, and care must be taken to minimise the rift between the technological rich and poor.

## **Housing type**

Movement from a family home is often triggered by difficulty in coping with a large house and garden. Therefore smaller housing units and small sections (although still with some outside living and garden areas) are generally preferred by older people (evidence for this come from New Zealand Census data presented in Chapter 2). 'Pensioner' and other housing for older people has often taken the form of bed-sitters and one-bedroom units. Consultations with older people show that these are not liked, especially by Maori, because older people wish to continue to entertain family and other visitors. Moving to smaller accommodation will usually require relinquishing possessions, which often has negative psychological impacts. Some older people may be coerced by landlords or families into moving into smaller units - local authority and public housing tenants especially fear this type of pressure and loss of control (Dwyer et al 2000).

It is desirable that houses incorporate somewhere for a carer to sleep, which might help to prevent hospital admission and/or institutionalisation during illness. Another issue is overcrowding, which is a social, rather than a design, issue. It may be encountered especially by older Pacific people and Maori, who are more likely to live with extended family members (see below and Chapter 2).

## **Under-occupancy**

Managers of rental housing are concerned about the efficient use of housing stock – some older people may be living in units larger than their (perceived) needs. This gives rise to what may be seen as an under-occupancy problem and is especially likely with respect to social housing, where families may be awaiting larger housing units. Policies of ‘decanting’ older people living alone, or with a spouse only, have sometimes been adopted. These have often given scant regard to the wishes of the older people, and assume alternative accommodation is available in appropriate locations. There needs to be a balance between optimum use of housing stock and meeting the preferences of older people. The provision of attractive alternatives to remaining in a large family home, in terms of design and location, will contribute to meeting both objectives.

## **Location**

Given the possibility of reduced mobility in old age (and possibly loss of driving ability), older people often express a preference for housing accessible to shopping, public transport and medical care. Housing developments located in attractive surroundings, but remote from services and opportunities for social contact, may be acceptable while people have access to private transport, but may be recipes for social isolation when they have to live without a car. External design and lay-out features can help to promote safe living and choices for level of participation. Technological innovations can also play a part.

Concentration or dispersal of housing for older people is discussed at length below and there are advantages and disadvantages to both. Where older people are concentrated in an area, service provision may be more economic and feasible. However, concentrations of older people run the risk of being labelled ‘grey ghettos’. Several of the organisations consulted (including Canterbury DHB and the Office for Senior Citizens) expressed concerns about retirement villages on these grounds. They can remove intergenerational interaction for older people and risk potential isolation from the wider community. This view prefers housing that incorporates all age groups.

Some areas develop as NORCs – naturally occurring retirement communities – of which the Kapiti Coast, parts of the Bay of Plenty and Nelson are examples in New Zealand. Older people may be attracted to such places for their climate, services and terrain. This encourages

service provision to meet their needs and makes it more economic. This may be positive, unlike concentrations of older people in run-down and deprived areas, which represent lack of choice and low levels of financial resources.

Other examples have been presented in Chapter 3, where housing for older people is ‘pepper-potted’ through the community. This allows a wider choice of location and facilitates the maintenance of social and family ties. If support systems work well to serve housing of this type, then it has many advantages. This is especially so where small clusters of housing for older people give the best of both worlds: - concentration but not ‘ghettoisation’, in the community but not isolated.

While only 10% of older people in New Zealand live in rural areas and rural centres, this group have special needs in terms of mobility and access to services, and hence housing location. Rural people in New Zealand, especially Maori communities, have identified particular issues of poor quality housing, difficulty in adapting or selling housing, lack of transport and isolation (Ministry of Health, 1997).

### **Scale of developments**

Specialised housing for older people may take the form of single houses with 10-12 residents, such as the Abbeyfield model; small clusters of units, such as some local authority and voluntary organisation pensioner housing in New Zealand; up to very large retirement communities. Sun City West, in Arizona USA, is an extreme example of a very large retirement community: it is a segregated community of 31,000 inhabitants, with no one under the age of 55 (OECD 2003, p54).

Larger developments will take advantage of economies of scale, making it possible to have live-in ‘wardens’ or support people and a variety of recreational and supportive amenities. But smaller developments may be more companionable, less identifiable, more easily integrated into the wider community. ‘Pepper-potting’ of small groups of housing units, with an over-arching support system, typified by Compassion Housing in Upper Hutt appears to be a good model to promote such integration (Chapter 3).

## Integration or segregation?

This links to the question of whether specialised housing for older people should be integrated with or segregated from the wider community. The 2003 OECD report (p15) calls for choice. However, the report tends not to favour 'golden ghettos', which do not produce diverse or inclusive, urban places and 'luxury geriatric parks' which sideline older people from urban life to the detriment of all. Instead the report calls for housing for older people that is integrated within the urban environment, which does not look different or appear like an institution. But whether this is achieved depends on suitable housing being available. In Denmark, small groups of such dwellings are located in spaces between apartment blocks. In New York, old and difficult-to-rent flats have successfully converted to 'service homes' for older people. Such developments can be facilitated or impeded by zoning, planning and building regulations.

Integrated housing for older people can not only help in preserving social and family networks but also in increasing densities, controlling sprawl, and reducing travel in large urban centres. Services can then be provided at home or at day centres, and non-elderly groups could also use such centres. The mixing of age groups along these lines, which will facilitate family support of older people and the linking of service centres, fits a concept for Maori housing put forward below.

Should older people have to protect themselves from urban society or should urban society be reshaped to make all places work for older people? (OECD 2003, p11.)

Four general conclusions come from the OECD discussion of integration or segregation.

- More small housing units will help people of all ages
- Housing to allow families and older people to live more closely to one another is beneficial
- Mainstream housing needs to be build to 'lifetime' standard to can be occupied by people of all ages and all levels of disability
- Specialised housing must be properly designed.

Individual predilections vary. Some older people prefer living in enclaves with other older people and some prefer mixed-age neighbourhoods. Planning for diversity in housing provision would allow such choices to be expressed and respected.

## Providing care for dependent older people

The need to integrate housing and care needs is a major theme of this research. Following the 'continuum of care' framework, intermediate housing can encompass highly independent to highly dependent lifestyles. At the more independent end of the scale of housing for older people in New Zealand are retirement villages and public sector pensioner housing (and overseas this includes co-operative housing) in which people are expected to take care of most of their own needs. However, home care services can usually be supplied in these types of housing on request or after assessment. The OECD (2003 p91) identifies four levels of housing for older people in Norway:

- senior housing: - high standards flats, chosen for preference, active lifestyle
- adapted housing: - separate flats close to services
- assisted housing: - collective areas and services
- nursing flats: - the 'new nursing home'.

Moving along the continuum of 'sheltered', 'very sheltered' or 'assisted' housing, we find a higher and higher level of care and support linked to the accommodation. This comes closer to residential care, but many countries are developing new ways to mix housing and care in non-institutional settings. In some places supported housing is replacing residential care, as in Denmark (see, page 100 Chapter 3). Existing institutions, in both Denmark and Sweden, have been converted to self-contained units with appropriate care services. Day care and respite centres allow people to remain in their homes while receiving care. The aim is 'to provide older people with autonomous housing while proposing an appropriate caring environment for the most vulnerable'. This may require some expansion of specialised nursing home beds, eg for dementia patients. However, in Saint Nazaire, France, long-stay residents (some with advanced dementia), were moved into houses close to the town centre (Chapter 3 page 104).

Nursing homes and old age homes can be instrumental in outreach activities to help elderly residents in the surrounding community, whether in intermediate housing or their family homes, to age in place. They can provide recreation, physical therapy, bathing, meals, emergency assistance and respite care. This reduces the need for older people to move towards service (the services come to them) and could also allow such services to operate more efficiently with a wider catchment area. It is debateable whether there will always be a need for some institutional accommodation, for dementia units and for hospital level care.

People may favour residential care based on safety concerns on their part or that of their families or GPs. But there needs to be a balance between risk management, autonomy for older people and the potential for loneliness and isolation. Unless there is appropriate supported accommodation to assist older people to stay in the community these concerns will persist.

In future the emphasis might shift towards a new concept: the 'rest home in the community', which will provide short-term, respite and convalescent care and will be a hub for the provision of services to older people living in the community, such as meals, laundry, personal care and nursing services.

## **Housing for older Maori and Pacific people**

### **Older Maori**

Consultation with Maori about housing for older people, carried out by Tautari Huirama of Te Mauri Te Kore Ltd, took the form of interviews and focus groups with kaumatua, discussions with Maori organisations, including housing providers, health care workers and health advocates, and with community leaders in various parts of the country, some in person and some by telephone (Appendix 1).<sup>25</sup> Te Puni Kokiri gave written responses to the researchers' questions. In addition housing for older Maori was part of discussions with public and voluntary sector agencies, including local authorities, in particular the New Plymouth District Council.

Information about current and likely future trends relating to the older Maori population is presented in Chapters 2 and 4. By way of introduction, the following points are important (noted by TPK in their submission).

- The Maori population is currently relatively youthful, with a median age of 22 in 2001<sup>26</sup> (the median age of the total population is 36 years). This is expected to increase to 26.8

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<sup>25</sup> There was some resistance to participation in the consultation, we were asked not to use some information which was originally offered and not to quote some of the respondents. We respect these requests but therefore the discussion is not as full as we would have wished.

<sup>26</sup> Statistics drawn from the Statistics NZ website – population monitor.

years by 2021, although this will still leave the Maori population with a younger age structure than the total population.

- The fastest growth during this 20-year period will be amongst Maori aged over 65. Their numbers are expected to treble from 20,000 in 2001 to 57,000 in 2021. This age group will make up 8% of the Maori population by 2021 compared to its present 3%. There will be a large increase in the numbers of Maori aged 85 and over although, in overall terms, the numbers will remain very low (Chapter 2).
- Maori differ from non-Maori in a range of socio-economic variables, having lower rates of: employment, homeownership, earnings, health (including life expectancy), and educational outcomes.
- An increasing proportion of older Maori are living alone or with a spouse only.

Maori are therefore a growing proportion of the older population, but are likely to have low incomes, few savings and a history of living in rental accommodation, some of it low quality.

## **Special Needs and Preferences of Older Maori**

Older Maori share with older people in general a range of special housing needs and preferences, but, in addition, their cultural preferences need to be recognised. These include a holistic perspective on life, whereby physical, mental, spiritual and family (whanau, hapu and iwi) wellbeing are inter-related. The cultural roles of kaumatua and kuia bring with them housing requirements in terms of housing form (space to accommodate visitors) and location (access to marae and places of cultural significance). Maori place considerable emphasis on kinship, authority, and inter-generational links. This helps to maintain the health of older people by avoiding isolation and despondency. It honours them as a source of wisdom, and can help to stabilise family situations. One respondent told us that grand-children are ‘what keeps older Maori alive - they can show the parents where they are being too hard on the children and be more relaxed’. Maori have a traditional preference for extended family living situations, but these may also arise from financial limitations. However, the proportion of older Maori living in such households is declining. This is because many younger people move away from their elders to find work. Some older Maori consulted for this study expressed a general preference for living independently of their children and grandchildren, who can be quite demanding on their time and energy, while still being close to other

kaumatua, for congenial company. They want their whanau nearby, but not necessarily living with them.

Older Maori often prefer care from their children when they become dependent. This allows the older people to have more control over the care and caregivers than they would have with mainstream services. It suggests that housing for kaumatua should not be seen in isolation from the housing needs of the wider Maori community.

Concerns surrounding the currently low, and falling, Maori home ownership rates and consequent high proportions in rental situations are outlined in Chapter 2. Individuals and families living in rental housing through their working lives are likely to remain as tenants as they move into retirement, and so face continuing high housing costs and increased risk of living in colder, damper and low quality housing, with consequent risks to health. Rental housing also offers less security of tenure than ownership, which is a concern for older people. Maori who do achieve homeownership may still enter their later life with low levels of capital. This arises from the practice of passing homes on to their children, and even when this does entail some payment the amounts may not be large enough to purchase specialised housing. Of concern to some older Maori who own property in coastal areas has been rapidly escalating house values, bringing greatly increased rates payments. This may make it difficult for the residents to remain on tribal land that has been in their families for generations and has special significance.

## **Kaumatua Flats**

The former Department of Maori Affairs was funded to provide assistance to marae and other Maori organisations to build housing for older Maori on Maori land and/or close to marae (Chapter 2). Kaumatua flats are generally similar to local authority pensioner housing except in their location and now share some of the same problems. Kaumatua housing schemes have attracted criticism over a lack of design flexibility and units that are now considered too small (many were bed-sitters). Because some were built on marae grounds the residents often became the de facto providers of services on the marae. Blocks of flats were sold in the mid 1980s and currently there is no funding available specifically for new kaumatua flats.

## **A community-based initiative - Pa o Te Ora Incorporated Society**

This exemplifies a range of community initiatives which are being considered throughout the country. Pa o Te Ora is a community agency in a small town north of Whangarei. This agency works with youth, domestic violence offenders and victims of abuse. They have a special project under way aimed at developing accommodation for kaumatua. The vision, as articulated by Sharon Pickering, the agency manager, is 'to provide a wrap around service for kaumatua in our district'.

The housing project for has been under way for some time and has recently been given a grant to conduct research. This will start in July. The site in mind is a 5 acre, 9 bedroom complex in the township of Hikurangi. This property has great potential for a kaumatua papakainga alongside a vegetable and flower garden within a landscaped complex. The house and site is not on marae land and will have to be purchased, but will be closely integrated with the local marae.

The concept is that there will be a health clinic on the property, a van for transporting and picking up kaumatua and that young people will come in to help plant the gardens. This will allow youth to support kaumatua and kaumatua to pass on their skills i.e. planting, te reo and Maori knowledge. At some time in the future papakainga housing for families could be developed, if space allows. At the moment, however, the organisation is struggling to secure sufficient resources to realise its dreams.

## **Looking to the future**

Increasing longevity among Maori will lead to a growing demand for low cost rental housing for kaumatua (this is the conclusion reached by analysis in Chapter 2). Many Maori now entering later life have migrated from rural areas to seek work and some may wish to return to tribal homelands. The discussions with kaumatua included people who had moved in this way. They found the spiritual and psychological benefits of returning 'home' very rewarding. On the other hand, they were away from their whanau, who had remained in the city, and needed time to re-establish their community links. They were also worried about what would happen if they had urgent health needs. If this preference is to be met, there will be challenges in terms of providing required health and support services in relatively isolated areas. One respondent suggested mobile health clinics as a way of surmounting this problem. Where older Maori require high levels of daily care, the challenges of rural living are even greater. The Waimarino Trust proposal for a 'social village' in Raetihi will meet some of

these requirements in a very small town. This, and similar, proposals are inclusive, housing both Maori and Pakeha older people.

On the other hand, kaumatua now living in rural areas may wish to move into towns in order to be closer to family members and to gain better access to primary health care and social support services. Diversity in housing and location choices and preferences is likely to increase in the future, as Maori educational levels improve and flow through into income levels. There is a danger, as TPK point out, of assuming what 'generic' Maori need.

Government is now playing a role in encouraging community-based organisations to provide supportive housing for older people. This implies ongoing partnerships with Maori organisations of the types mentioned in Chapter 3 - Ouae Marae housing in Waitara and links with the New Plymouth District Council. The latter illustrates some of the procedural barriers which need to be tackled. NPDC is currently working with its iwi relationship team to reduce unreasonable restrictions on the development of land around marae, and other Maori land held communally under one legal title. These restrictions currently limit Maori from using their lands to develop social housing programmes. Parties have been working to strike an appropriate balance between requirements under the Resource Management Act (RMA) that enable social and cultural development and protect Maori cultures and traditions, and RMA sections that seek to avoid, remedy or mitigate adverse environmental effects (Beca Carter Hollings and Ferner 2003).

There is continuing debate over the long-disputed Pekapeka block in Waitara. Te Ati Awa wish to use this land to develop housing for local Maori whanau and kaumatua. This prospect has been delayed in light of NPDC's recent announcement, which will see the council sell the land back to central government, for subsequent return to Te Ati Awa as part of its Treaty Settlement ('Council to sell Waitara leasehold land to Government' *The Daily News*. 31 March 2004). It is envisaged that other Taranaki iwi will develop low cost housing for their kaumatua once their respective Treaty settlements are resolved. Ngati Ruanui in South Taranaki is developing a social and economic arm that is likely to include a housing programme for its older people.

TPK and HNZA are working with iwi groups to produce affordable and good quality housing for Maori people, including some for older people. Initiatives, located in Northland and the East Coast, are taking a broad approach, involving other agencies, for example in promoting

fire safety and community development, improving transport, health and education opportunities.

Overall however, there is likely to be greater demand in urban areas. Constructing suitable kaumatua housing in urban areas will recognise the preferences of some older Maori to live in town and cities. It will also, in the opinion of some respondents, help to address social problems being faced by Maori families who are dislocated from their older people and grandparents, and help kaumatua to fulfil their role as mentors. However, as mentioned above, the availability of land for new building, or of existing accommodation to renovate, poses significant barriers. There have been suggestions of Maori groups taking over existing council units (as voluntary organisations have already done, for example in Upper Hutt). There is recognition that any changes would need to be balanced with the rights and needs of existing tenants.

A concept being put forward for the future by Tiopira Rauna, working with Te Ngawari Haurora Charitable Trust, is a 'Maori urban village' centred on kaumatua units. This would have some of the features of a 'social village', such as being a centre for service delivery to the community as a whole, but would house mixed age groups (similar to the long-term concept for Pa o Te Ora). It would incorporate services and housing for older people, as well as for their families – ie their children and grandchildren. While the older people will have their own self-contained living spaces (built to accommodate the highest level of disability needs), family will be close by, and the links between kaumatua and their mokopuna will be ensured. Possibilities include pensioner units, kohanga reo, and health services for older people at ground level, with family accommodation above. This should ensure that older people retain their independence, while also receiving care from their families and from health services, and has the potential to reduce the need for institutional care.

In summary, feedback from our consultation identified four essential ingredients in a model of housing for older Maori people and their whanau.

- **Kaumatua accommodation**

Kaumatua have their own residential space - a place where they can live, mingle and converse or where they can have quiet time. A place where they can interact or not interact as they choose, not forgetting that the whanau is near by.

- **Papakāinga for the family**

This is a place where the family/whānau will live. Kaumatua can visit them or the whānau may visit the kaumatua.

- **Health Clinic**

A health clinic should be a prominent feature, with health practitioners working from this clinic on a regular basis.

- **Marae area**

A place where there is the marae complex is easily accessible, so that kaumatua can be as interactive as they want to be. A place where kaumatua can walk, sing and relax.

Kaumatua complexes that work well, are those that meet cultural, spiritual, physical, mental and emotional needs, where the food is Māori, the language is Māori and the kaupapa is whakawhānau.

## **Older Pacific people**

This section draws on focus groups undertaken in Auckland and Wellington, in a consultation programme run by Margaret Southwick of Whiteria Polytechnic, and on an interview with officials from the Ministry of Pacific Island Affairs (MPIA). Four focus group meetings were held with a total of thirty-four participants from a range of island groups, though they were predominantly Samoan, with a spread of ages from 20s to 50s (Appendix 1). Before turning to the specific housing situation and needs of older Pacific people, it is worthwhile summarising some contextual factors for the Pacific population as a whole.

- A high proportion of Pacific people live in rental accommodation, especially HNZC housing (Chapter 2).
- This links to generally low income and savings levels (although homeownership is still generally desired and being encouraged by MPIA).
- Housing choices are limited by low incomes so that preferences may not be realised.
- Pacific households tend to be larger than average, including many multi-generational families. A high proportion of older Pacific people live with their children and other relatives (Chapter 2). This may lead to overcrowding.
- Larger households and cultural preferences may require special design features.

- An increasing proportion of Pacific people have been born in New Zealand. There are different attitudes between this group and island-born people, and between the generations, which influence housing and living preferences.
- The average life expectancy of Pacific people in New Zealand is lower than for the total population and this, combined with the migration history of the community means that it contains comparatively few older people. However, the numbers are likely to grow rapidly in the next few decades (Chapter 2).

### **Special needs of older Pacific people**

There was a great deal of similarity in the needs and problems identified by the focus groups. The most frequently identified housing issue was financial accessibility and affordability. The close relationship between housing and health was highlighted, as were family and cultural needs and cultural safety, and general housing design was discussed.

### **Financial accessibility and impacts on health**

Affordability was the most frequently identified concern for members of the Pacific peoples' focus groups. For many Pacific elders, superannuation is their only form of income, and there are many demands on that money. Housing, transport, food, power, medical and hospital care, and the traditional demands from church and community to contribute to large family and community events, particularly funerals, all place a large financial burden on Pacific elders. Not to be able to fulfil these obligations can be shaming and can lead to heightened family tensions.

Financial pressures mean that Pacific elders often cannot make necessary repairs to their homes. Participants reported elders living in sub-standard conditions, not being able to replace broken windows or repair leaking plumbing or roofing. Such conditions inevitably create health problems. Limited incomes and expensive accommodation also lead to overcrowding with accompanying health and social problems.

### **Family and cultural aspects**

The contribution Pacific elders make to the continuity of cultural values and beliefs was acknowledged by all. Elders 'uphold the culture for future generations'. They provide 'spiritual leadership and knowledge of traditional medicines and healing'. They are the

bearers of the culture and the ancient wisdoms, in way very similar to that of Maori kaumatua.

Traditionally, older Pacific people have lived with their families, providing an interface between the generations. But the expectations around their role, coupled with the changing nature of Pacific families, are placing some elders under a good deal of stress. The general consensus was that 'you need two incomes to run a household and run a family', and Pacific elders play a vital role in enabling parents of young children to work by providing childcare. However, respondents noted that elders often prefer to have a 'bit of distance between themselves and their families.... They get fed up with having their grandchildren dumped on the all the time'. These views echo the sentiments of older Maori, mentioned above.

## **Design features**

While focus group participants identified a number of design and environmental features that would help make housing more suitable for Pacific elders, Pacific features are already addressed in the *Pacific Housing Design Guide* (Faumuina and Associates 2002). Other desirable features, some of them common to older people in general, include:

- Accessible design, especially sufficient space in toilets, bathrooms and hallways for larger-framed people, and for larger-framed people *and* their caregivers.
- Extra living space. An extra bedroom enables the older person to have visitors. A bed-sitting room affords no privacy.
- Small flat sections within easy access of shops, transport, medical centre and community centres.
- Plugs and space for mobility scooters.
- Emergency systems.

## **Future directions**

In general, focus group participants were unwilling to generalise about the future. Some felt that it was inevitable that fewer Pacific elders would live in extended family situations. 'We live in a country where money is needed to pay for everything' and the economic pressures experienced by Pacific families mean that they will not be in a position to be able to care for their elders at home. Tensions exist between the desire to care for older people, thereby keeping traditional values alive, and economic realities. It was agreed that whether or not Pacific people continue to live in extended family situations should depend upon individual

family relationships, rather than being something people felt compelled to do because of economic necessity, or because that was what 'society' felt they should do. Diversity and choice are desirable for this group, as for older people as a whole.

However, it was also acknowledged that Pacific people are less able to prepare for their retirement than other New Zealanders. Low incomes and poor health, which often force early retirement, combine to mean that Pacific elders will require support to access appropriate accommodation.

The focus groups discussed the possibility of community-based sheltered accommodation for Pacific elders, which would not only ensure that cultural and spiritual needs were met, but could be a way of building relationships between different Pacific ethnicities and cultures. A neighbourly environment was highlighted as important whether the home was part of a retirement village, a cluster of housing for older people, or part of a diverse neighbourhood. The 'social village' concept for older Pacific people was seen as a model to pursue. This would ideally include individual units, with appropriate design features, as well as communal areas for extended family events, which would bring wider family into the development. This could be a way not only of meeting the needs of the older people but also of giving them a social purpose – managing the communal area and offering cultural learning for younger people.

There are some examples of such initiatives, under development or being discussed. One is a partnership between HNZA and a Tongan church community in Auckland. Twenty-two housing units are to be built on church land with the possibility of housing for older people to follow. This has been under development for several years and has faced delays in gaining consents. Other such developments are possible, especially in Auckland, but also in Porirua, linked to the Tokelauan and Cook Island communities.

In summary, the benefits of appropriate housing for older Pacific people were highlighted by focus group discussions. Better housing would lead to less stress for elders and better health. A healthier older population could participate more actively in the community and be less costly to support. Healthier elders would create less of a burden on families (although being a 'burden' is not how older people are seen in traditional Pacific culture). A culturally safe environment would build the self-esteem and identity of Pacific elders and in turn they would be able to provide support for younger generations about culture, beliefs and values.

## **Older women – how are they different?**

Insofar as women represent more than half of the older population and this proportion increases with age, the whole discussion of housing options for older people in New Zealand relates to women. Women predominate in housing developments for older people by virtue of demographics. Gender analysis indicates that there are differences in the situation of men and women, which persist up to the end of life. These relate to demographic, social, economic and health factors (Chapter 2).

Women, on average, live longer than men do. Despite this they have a proportionally higher risk of chronic illness and disability in later life. They are more likely to be widowed and to live alone in later life. At age 85 plus, half of men still live with a partner, but only one in ten women do so. Older women are more likely than men to be caring for a frail partner in old age and their services greatly reduce the need for residential care for their partners.

Following from this, women predominate among residents in residential care. The present generation of older women are also less likely to be drivers than men and tend to give up driving earlier. These patterns suggest that the needs and preferences of older women should be at the forefront in the design and location of the supported and extra-care housing for single older people.

Women, and especially older women, are economically disadvantaged compared to men. They have fewer financial resources and assets and, despite universal provision of New Zealand Superannuation, income differences in favour of men persist up to the oldest age groups. Because of lower levels of workforce participation, women have lower levels of supplementary pensions and income from assets, businesses and investments. Women are more likely than men to be renters in later life. This arises from their lower income levels and because many have experienced discriminatory matrimonial property settlements in the past.

These trends and characteristics may change in the future. Differences in life expectancy between men and women may narrow, leading to older people remaining partnered for longer, with consequent implications for housing and the provision of informal care. Oncoming generations of women are likely to have enjoyed higher levels of personal and economic independence, arising from higher levels of workforce participation and educational opportunities.

However, while expectations persist that women will shoulder the main responsibility for unpaid care, of children and dependent adults, women may remain at a disadvantage. Time

devoted to unpaid work reduces the opportunity to earn, to accumulate assets and to achieve homeownership. Women with family responsibilities may continue to suffer disproportionately from family and marital instability.

Few examples of housing specifically for older women appear in the literature, although groups of women may take advantage of co-housing models, described in Chapter 3. Agencies concerned with housing for women in New Zealand, such as the Christchurch-based Women's Housing Trust, tend to concentrate more on younger women, for example women seeking to escape from, or re-house themselves after, partnership breakdown or family violence.

## **Whose responsibility? The role of the Public Sector**

If special types of housing for older people are indicated, to meet special needs and provide care and support, then whose responsibility is this and who should take the initiative? Even if a housing development is totally user-pays, as is the case for many retirement villages, someone or some agency has to initiate it. Even if the development is on a partnership basis, there has to be a start and a protagonist (in the sense of someone to take the leading role).

The question of responsibility is somewhat different and has strong policy implications. Social policy is based on beliefs and assumptions about where responsibility lies for social provision and what the range of this provision should be. Frequently, however, the public sector has seen housing provision – especially for low income and disadvantaged groups – as wholly (but more usually partly) its responsibility.

The general feeling among agencies consulted for this study is that individuals should be responsible for their own housing needs as far as possible. The majority of New Zealanders (90%) are able to satisfy their own housing needs operating within the private housing market, which is made up of the buyers and sellers of private housing, home finance/mortgage institutions, property investors and landlords, builders, developers and real estate agents. Meeting needs in this way is consistent with the valuing of autonomy and independence implicit in Positive Ageing and 'ageing in place' policies. This suggests a government policy to ensure that as many people as possible are able to manage their own housing needs (with good choices available).

However, there will always be people who require support to achieve adequate housing, from their families, communities and government agencies. Thus policies must also ensure that those who are not able to care for their own needs are supported to 'age in place' as long as they are able or wish to. Obviously this will depend on public resources, for which there are competing priorities.

## **The role of Central Government**

Housing is a key area where government can influence social and economic wellbeing and housing inequality is a significant contributor to social and economic inequality (HNZC 2004). The Housing Strategy consultation document notes that central government has two direct roles in housing. The first is to regulate the housing market and housing quality. The second is to provide housing assistance to lower-income households that have difficulty accessing affordable and suitable housing. The majority of current housing assistance is provided as state rental housing or as an income supplement (the Accommodation Supplement) to low-income tenants, boarders and homeowners. In recent years, however, the government has expanded its range of housing assistance. The most relevant initiative for this study is funding local government and other social housing providers through the Housing Innovation Fund.

In this context, how does housing for older people differ from housing provision in general, with respect to government responsibilities? In terms of market regulation the government has recently intervened with respect to retirement villages. Quality standards are applied to residential care homes and service providers (through health sector structures). It may be worth considering how overseas standards and codes for supported housing could be applied in New Zealand.

Government supports older people through retirement income support, on a universal basis. Evidence from *Living Standards of Older New Zealanders* Survey (Fergusson et al 2001) shows that the majority of older people are meeting their housing and other needs adequately.

Housing assistance to all age groups is delivered mainly through the Accommodation Supplement (AS) (Chapter 2). Clearly only a small proportion of older people are receiving this benefit. This is largely because home ownership generally reduces housing costs below the threshold for AS. Also a considerable proportion of older renters are in state houses with income-related rents. However, it is possible that many older renters in the private sector are

not receiving the assistance to which they may be entitled. How can this assistance be better directed to meeting the needs of older people and how can it be better integrated with other forms of support? The same questions arise with respect to ACC and DSS funds for house renovations. A review of existing housing assistance for older homeowners, through central government agencies, would be beneficial. This should also look to the future, posing questions about the overall maintenance of the national housing stock. A review of this type could be widened to consider the role of the public sector as a whole, including the roles of territorial local authorities and DHBs.

Despite the reasonable income and housing situation of most older people in New Zealand, there are still a proportion (5-15%) of the poorest older people who, in the interests of combating poverty and social exclusion, require assistance from the state. This group are unable to take up market options, as the private sector tends to seek out the more lucrative groups (as seen in the development of retirement villages). Policies to combat social and economic exclusion and poverty will increasingly have to include provision for older people (OECD 2003 p24).

The possible savings to be made by reducing residential care costs, outlined in Chapter 2, could be used to improve housing and support services in the community. This report provides some ideas about how this might be done, drawing on concepts and models developed in New Zealand and overseas. This should include the evaluation of financial instruments for older people's housing and social care – incentive schemes, life leases, home equity conversion, tax relief, shelter allowances, various kinds of financial support for independent living. Reaching beyond the housing area, 'ageing in place' and keeping older people in the community as long as possible have implications for the support of informal carers.

More specific ideas and models on high-level care for older people remaining in the community include grants and subsidies for social services to avoid institutionalisation (Australian Community Aged Care packages - CAC and Health and Community Care programme HACC), tax exemptions for home help (currently operating in France), keeping an older person's house available on the assumption that an institutional stay may be temporary, and tax cuts for landlords renting out serviced flats to older people.

## **The role of Local Government**

The Local Government Act 2002 can be seen as putting local government at centre stage in terms of identifying housing need and options for meeting that need.

(McKinlay Douglas 2004 p17)

In the past, local authorities received subsidies and low interest housing loans from central government for housing and most of the current stock of pensioner rentals originated from these initiatives. As outlined in Chapter 2, these initiatives are no longer available. Many local authorities have sold their pensioner rental housing, no longer seeing this as part of their core business, but one more appropriately undertaken by voluntary organisations.

However, under the Local Government Act 2002 each council has a statutory role to promote the social, economic, environmental and cultural wellbeing of communities in its district or region, in the present and in the future. This means that local authorities will have to be concerned not just with their own housing assets (the landlord role) but also to identify the community's housing-related outcomes and to decide whose responsibility it is to deliver those outcomes.

Local government at 'centre stage in terms of ... housing need and options...' suggests that housing strategies should be linked to city planning and incorporate transport and services. How this will work out in practice remains to be seen in most cases, although New Plymouth and Christchurch provide examples where housing and the needs of older people are being seriously considered (Chapter 2).

Through new funding (the Housing Innovation and Local Government Housing funds) central government is again encouraging and financing local government provision of housing. HNZC is engaging with local councils to strengthen and grow their portfolios. Priority is given to proposals that demonstrate a council's long-term commitment to maintain and build up its social housing portfolio and meet identified social needs, which includes the needs of older people with low to moderate income households or specialised housing needs.

## **Other agencies**

The main business of the DHBs is the provision of health services. Such services are essential to good quality of life for older people, and also closely linked to housing need (Chapter 1). DHBs do not generally see themselves as taking the lead in housing provision.

Some are, however, willing to consider partnerships with other agencies. The management of DSS funding for older people has recently been devolved to DHBs. This allows them more autonomy to explore alternatives to residential care for frail older people, and, as asset limits are raised for the consumers of residential care, funding to DHBs may increase.

Voluntary agencies have no direct responsibilities for housing provision, but sometimes take the lead in housing initiatives for older people, as the examples of Abbeyfield and the Waimarino Trust in Chapter 3 show. They tend to be limited by funding and hence also require partnerships, often with central and local government agencies.

## **Funding housing for older people**

Housing is a capital asset, intended to be durable, and requires funding both for its construction and also for its ongoing maintenance. In the case of older people, given the close association between housing and services, which has been stressed throughout this report, funding may also be required for care and support.

Funding may come through the housing market and, traditionally, this is how individuals and households in New Zealand have housed themselves. This frequently requires access to financial markets through banks and other mortgage lenders, who are not also housing providers. In historical terms, the public sector has been both provider and funder of housing, especially for low-income groups. In recent years, these functions have been split, initially for ideological reasons, but more lately partnership approaches have found favour. A range of ways in which both capital and ongoing funds can be provided are mentioned in the Chapter 3 examples.

Funding and the 'silo' approach of government agencies are seen as barriers to new and innovative developments. Many voluntary organisations and community groups lack capital for development and may find it difficult to access to funding from commercial banking, as they have no profit stream. Finance charges may result in higher costs for low-income groups seeking housing. Central government thus has a crucial role in funding, which might take several forms - seed funding, commercial lending, facilitation, providing guarantees, interest subsidies and keeping compliance costs at a reasonable level.

## **The Housing Innovation and Local Government Housing Funds**

In 2003, \$63 million was allocated to a four-year programme of social housing demonstration projects to be developed in partnership with iwi, third sector housing providers and local government. This programme - the Housing Innovation Fund (HIF) and Local Government Housing Fund - is intended to encourage the development of an innovative alternative social housing sector that is able to provide affordable and secure rental housing and home ownership opportunities to low-income New Zealanders.

The key reason to support alternative social housing providers is that they charge affordable rents and their tenants are more likely to enjoy security of tenure than in the private sector. Rents are generally set at cost recovery level and, where a small surplus is generated, it can be reinvested to develop additional affordable housing to meet ongoing demand.

To access the Housing Innovation Fund, groups need to:

- meet at least 15% of the costs from their own resources (including land, labour or voluntary contributions)
- target low-income or special needs groups
- have good property and asset management policies in place
- have demonstrable community support.

Funding is also available for provider development and feasibility studies, in recognition that many potential providers of social housing, including hapu/iwi and urban Maori groups, are in the early stages of developing expertise in this area (HNZC submission to the study).

Supporting alternative social housing providers offers both social and economic benefits.

Social benefits include:

- improved service delivery to specialised client groups
- pooling resources and expertise
- growth of social capital in communities by involving community members in developing and delivering local housing solutions.

Economic benefits include the ability to attract investment from local government, private partners and community-based organisations. Social housing has the potential to be a

significant area of social investment for philanthropic trusts, socially responsible businesses and local government.

By June 2004, several HIF contracts were being negotiated and in addition several local authorities have been enabled to update and renovate their pensioner stock (Chapter 2). Many of the voluntary groups consulted in this study have great hopes of the fund to further their plans for supported housing for older people. They clearly identify lack of funding, especially for capital costs, as a barrier to such developments. However, they frequently find difficulty in accessing what they need, citing the 'silo' mentality, lengthy delays and high compliance costs. It seems likely that the funds allocated will be over-subscribed, but successful demonstration of the benefits mentioned above may lead to extension of the funding base.

## **Partnerships**

Partnership approaches are a way of using the resources of government agencies alongside the community-level experience and knowledge of the voluntary sector. Partnerships between central government, local government, DHBs, the voluntary sector and possibly private business may provide a way ahead for housing which has the extra dimensions needed by older people and also the special cultural dimensions involved in housing for Maori, Pacific people and other communities interested in exploring innovative ideas.

The HNZC makes two important points about partnerships – firstly, they need to build slowly if trust and effective relationships are to be developed, thus it may be some time before significant housing outcomes are achieved. Secondly, government agencies must have realistic expectations as to the time and energy available on the part of stakeholders in community-based organisations and continue to build their own capacity to engage appropriately. The partnership model has already been adopted by HNZC with respect to group housing, but to date mainly for people with mental and physical disabilities and iwi groups (mainly through rural housing initiatives). The Housing Innovation Fund clearly has a part to play in developing such partnerships, although funding may not be the only barrier, as the above remarks suggest.

Several different types of partnerships emerged from the consultation phase of the research:

### *Central Government- Voluntary Sector Partnerships*

An example of this is partnership between HNZC and Abbeyfield New Zealand. This has led to the development of an Abbeyfield House in Hamilton, which will accommodate residents in 10 one-bedroom suites, with communal rooms and a housekeeper's flat (Chapter 3).

### *Partnerships with Local Government*

The Canterbury DHB is working with the Christchurch City Council through the LinkAGE Strategy Action Plan, with regard to subsidised/supported housing.

The Christchurch City Council is discussing partnerships with Abbeyfield, the Baptist Church and the Richmond Fellowship, as well as with local Maori groups, to develop supported housing.

### *Partnerships between Central Government Agencies*

Partnerships are also needed between parts of the public sector – most notably between health authorities on the one hand and HNZC and local authorities on the other. This epitomises the need to combine housing and care for older people. The *Health of Older People Strategy* and the *Positive Ageing Strategy* stress the need for intersectoral collaboration:

The Minister and DHBs will work with other agencies to advocate for low-cost housing options for older people on low incomes, subsidies for heating and insulation and universal design of houses to suit all ages....the Ministry of Housing will collaborate with funders and providers of social housing ...to promote the development of culturally appropriate supported living options for older people (*Health of Older People Strategy*, p44 and 59).

Partnerships, cooperation and cost-sharing arrangements between government agencies and private and non-profit organisations are favoured in the current New Zealand policy climate and also internationally (OECD 2003, p169). However, the OECD found that, despite the fact that the 'mixed economy of welfare' approach and increasing reliance on voluntary sector *encourages* partnerships, sectoral fragmentation still characterises most implementation models across countries (OECD 2003, p167).

## **Whole of Government approach**

The above comment from the OECD epitomises what is often termed the ‘silo’ mentality, whereby government agencies do not cooperate effectively. This is often the perception of voluntary sector groups seeking assistance. As already noted, the rhetoric is for co-ordinated and holistic approaches to policy implementation and a ‘whole of government’ approach.

By itself, housing policy cannot guarantee desirable housing outcomes. Monetary policy, labour market policy, taxation policy, social assistance, health and disability and immigration policy have the potential to exercise as much, and sometimes more, influence on housing. The government is promoting inter-departmental collaboration in policy development to ensure that policies complement and reinforce each other across sectors.

The development of integrated models of service delivery (ISD), incorporating clusters of social agencies and departments and featuring partnerships with low-income communities are new attempts to address complex socio-economic disparity in a holistic manner. HNZC’s Rural Housing, Health Housing and Urban Community Renewal programmes all feature cross-sectoral collaboration arrangements particularly with health and disability and social services (HNZC submission to the study).

## **Management**

A range of management options for specialised older people’s housing is illustrated in Chapter 3. Several cross-cutting issues arise from these examples.

## **Tenant/resident participation**

In line with Positive Ageing objectives, participation in management by the older residents is desirable to promote autonomy and independence. European models of co-housing and cooperatives illustrate participation in housing management, as does the Abbeyfield model. Autonomy on an individual basis is a possibility even for very frail older people, as the Danish examples show. Tenant representation is possible even in more bureaucratic examples and consultation with residents on their views and preferences. The latter is now required for retirement villages in New Zealand.

## **Partnerships**

Where housing initiatives are on a partnership basis, special difficulties may arise in management. However, there are examples of partnerships working well, including the Maori and Pacific peoples housing schemes. Just as housing and health are inter-related, so housing and health service management must go together. In Britain local authorities are responsible for both housing and home care services. At the federal level in Australia there is a department of Health and Ageing. Such structures may assist in coordination.

## **Eligibility**

Who has access to specialised housing for older people? Who are the target groups? Some of the examples reviewed in Chapter 3 have an age limit, although sometimes younger people with significant disabilities are eligible. This is on the basis of shared problems with access and mobility. However, the results seem less good when people with psychiatric disabilities are housed with older people, as evidenced in the experience of Christchurch City Council.

Public sector housing often has income and asset limits on eligibility to ensure targeting at low-income groups (these apply in the New Plymouth and Christchurch examples).

However, eligibility in the case of some voluntary sector housing is less strict, as the examples of Abbeyfield and the Waimarino Trust show. In fact, where housing and support service costs are high (as, for example, in the Australian rental retirement villages, described in Chapter 3), older people may require income to supplement their superannuation – a high percentage of which is needed to pay weekly costs. Many older homeowners do not realise sufficient capital from selling their family home to rehouse themselves in retirement village-style housing. But the income they receive from investing the capital can make supported living options possible, while still leaving income to enable participation in the community. This suggests that homeownership should not debar older people from some of the desirable forms of supported living.

## **Support and supervision**

Older people often enter specialised housing (including residential care) because they require some supervision – of a caring rather than controlling type. Technology can assist with this. Alarms and monitors can reassure both the older people themselves and also their families and carers (examples cited in Chapter 3). However, as already noted, this should not become a substitute for human care and contact. Loneliness is often concomitant with old age,

especially for older women who are frequently widowed. It can have negative social, psychological and health consequences.

Social support is often delivered by family members, even if they are not in a position to provide personal or domestic care. Housing for older people should therefore promote rather than inhibit family contact. This is made clear in the examples proposed for Maori and Pacific people's housing. Wider social contact similarly provides a wide range of benefits, and can be promoted by thoughtful design – of individual living units and also of lay-out and location of housing developments for older people.

Home care services frequently make the difference between older people being able to remain living in the community and being institutionalised. They are therefore essential to ageing in place and housing initiatives to promote it. Access to health care is also a major consideration in housing for older people and is linked with transport needs – therefore housing location. Many older people choose housing for its accessibility to doctors and hospitals. Housing developments for older people often incorporate a link with health services. This can culminate in the 'lifecare' approach, where a retirement village or similar development incorporates options for independent living, supported living, residential care and hospital-level services. This type of development reduces the need for several accommodation moves in later life and also avoids social disruption as might occur when one marriage partner requires a higher level of health care.

## **Information and advocacy**

Just as housing for older people cannot be separated from their requirements for care and support, so there is also the need for information services to assist them in lifestyle choices. Older people often need to know about relative costs and benefits of housing and care options and there is little research information on the processes whereby people reach their decisions. A single point of contact for information on housing options and support services would be useful to older people, their families and carers. People also need more information about changing needs with age and about the housing market. This might include options for equity release. Examples of information services operating overseas are quoted in Chapter 3.

The Canterbury DHB told us they are exploring how information is provided to older people, families and their support people and also service providers. If the person is 'in the system' this information is usually provided by an assessor. But it may be more difficult to help those

who are making a 'cold' enquiry. In particular, the DHB are concerned to provide information which is accessible and easily understood by Pacific, Maori, Asian and migrant communities.

There is also a need for advocacy on the part of vulnerable groups of older people and for their involvement in planning for housing and community services. Health authorities have a part in this, as good quality and appropriate housing is an important dimension in health and wellbeing. There could also be a role for government in fostering the activities of groups which represent older people (such as Age Concern and Grey Power) – giving them 'voice and choice' – widely, and also more narrowly in the areas of housing and care needs. The OECD report (2003, p171) notes that such groups are frequently consulted in housing and service planning. They could play a valuable part in the planning and design of housing and also through feedback mechanisms on housing and service quality.

## **Attitudinal factors**

The social and psychological effects of housing conditions should not be overlooked. For older people, housing has a psychological value as embodying 'home'. Hence housing may be an element in perceptions of independence, identity and security, as well as control over one's environment (Keeling 1999). It may also represent financial (through ownership) and psychological security. Home is the locus of hospitality, reciprocity and social interaction. Thus, for example, having space to entertain visitors should not be underestimated as an aspect of wellbeing for older people. The attachment to home explains the preference for ageing in place. But with increasing delivery of high levels of care in people's own homes, the value of 'home' may be eroded as independence and privacy are threatened and a house may become more like an institution (Hale 2003). Many wish to remain in their local district even if they need residential care. It is ironic that the term 'going into a home' (residential care) has come to have negative connotations.

A special issue involves older people in Maori and Pacific Island communities and how housing could be part of helping them to retain their status and role and involvement with younger people, as these communities age.

However, attitudes do change and as well as current cohorts, the attitudes of oncoming generations of older people are important when thinking about housing and care needs. The current older generation are risk averse and often unwilling to spend on housing, for example

on adaptations and new technology, but the 'baby boomers' may be different. For example, attitudes towards inheritance could also be changing, possibly making equity release more acceptable. As on-coming cohorts reach old age, the effect of marital relationship breakdown and property settlements will make themselves felt in housing circumstances, as well as in other ways. The challenge is to encourage people to think about their needs in old age. Saving for retirement is only part of this. It might include considering what level of risk is acceptable when weighed against independence and also what lifestyles are appropriate. Oncoming generations of older people are likely to be more diverse in their experiences and may demand a wider range of choices in housing and other spheres.

## **Chapter 6. Conclusions**

### **The importance of housing for older people**

The ageing of the population will have significant implications for society and for the economy as a whole. New Zealand is not as far advanced along the track of ageing as many other developed countries and so is able to benefit from their experience. It shares some characteristics of these countries, but in other ways the New Zealand situation is unique.

Ensuring the wellbeing of older people will be a challenge, as the age composition of the population changes, requiring attention to be given to groups of older people who are especially vulnerable or disadvantaged. Housing ranks high among the factors which influence wellbeing, thus the availability of suitable accommodation to meet the needs of an ageing population, recognising diversity in needs and preferences, must be a central issue for policy and planning in all sectors.

Housing plays a variety of roles in people's lives – as well as providing shelter it is a form of investment and contributes to economic, social and psychological security. All these aspects are important for older people. Social and psychological aspects fall under the label of 'intangibles' in the cost-benefit assessments. These 'intangible' factors can be at least as important as the monetary costs and benefits of different housing options. Chapter 1 shows how housing conditions influence both physical and mental health, but this inter-relationship is not simple. Poor housing conditions are linked not only to physical and also to mental and social wellbeing. And most accidents involving older people occur at home, thus the housing environment may either protect older people from, or expose them to, the risk of injury.

All this suggests that improving the housing situation of older people, especially those in low income and other disadvantaged groups, will have a beneficial effect on their health, in the widest sense, and lead to a more resilient older population, as well as contributing to the objectives of current government policies. This can only happen, however, if care needs are linked to housing needs. Services providing care and support to older people who need them are essential for ageing in place to be successful. The challenge is therefore to deliver such services to older people in mainstream housing and also to those who choose to move to specialised housing, often with higher levels of care.

An approach is required which reflects a holistic view of the needs of older people and acknowledges the interdependence of aspects of life – housing, health, transport, social contact, activities and support. It implies the need to coordinate the activities of government agencies. Beyond this, an integrated approach will also encompass the activities not only of central and local government agencies, but also of the private and voluntary sectors, with an emphasis on partnerships.

This conclusion is supported from both the individual and the national perspectives. The analysis of models of accommodation which has been presented in this report highlights the importance of tailoring arrangements to the specified needs of the individual and the local community, including ethnic communities. The national perspective highlights the importance of health status (and hence care and support expenditure) as well as the many ‘intangible’ factors in the determination of overall wellbeing.

## **Housing tenure**

The important intervening variables in the association between housing and health are income and tenure. Low-income people are less likely to achieve homeownership, and renting is associated not only with lower levels of health and wellbeing, but also with social disadvantage. Rental housing is often of less good physical quality and in less beneficial locations. But, in addition, renters tend to feel less in control of their housing environment and hence of their wider lives, reducing independence and security.

The housing situation of older people arises from a lifetime of experiences. Whether or not they have achieved homeownership (or housing and other assets to sustain them in later life) depends on their previous ‘housing career’. Lifetime income, employment and earnings

situation and the experience of setbacks, such as marriage breakdown, business failure, serious illness or disability in earlier life, all influence the housing situation of people in later life. Maori or Pacific ethnicity and female gender are additional factors, operating through income levels and opportunities for workforce participation, in particular.

Whether the encouragement, or financial support, of homeownership is a sufficient measure to ensure wellbeing in later life is debateable. Levels of government retirement income support may assume homeownership, and be adequate on this basis, but measures of poverty indicate clearly the crucial influence of housing costs. The existence of the Accommodation Supplement acknowledges this. Whether or not retirement income is adequate depends, to a significant extent, on the level of housing costs.

Levels of mortgage-free home ownership are high, but there are significant differences in housing tenure patterns by ethnicity, which reflect average income levels and which persist into old age. The fall in ownership rates over the last decade has affected all age groups and is especially marked for Maori and Pacific people. These trends warn that current levels of home ownership in old age may not be maintained in the future.

## **Options for the future**

In looking to the future the report highlights three key themes. Firstly, there is a group of older people (mainly homeowners) who have a range of accommodation options open to them. Secondly, there is another group of older people (mainly non-homeowners and low-income homeowners) whose housing options will be limited. Thirdly, the association between housing and health status provides a public good argument to ensure accommodation for older people is high quality and appropriate.

## **Homeowners**

Ageing in place is clearly a favoured approach in New Zealand government policy and more widely. It is likely that the vast majority of older people in the future will be 'ageing in place', that is living in non-institutional housing in the community. If older people are going to remain living in their family homes and 'age positively' and healthily, then issues related to maintenance, renovation and adaptation of their housing must be addressed. This review suggests that important initiatives in the New Zealand context will include measures to

promote better insulation and ventilation, affordable and effective heating options, modifications to improve access and safety, and use of appropriate technology.

The development of appropriate and comprehensive support and information services to assist older people through the process of upgrading and/or moving to other accommodation will be extremely important. This will probably need to be preceded by ‘audits’ of housing condition and heating efficiency, as well as safety audits.

Assistance with ongoing housing costs, especially rates, is another issue. However, there is the potential for home equity to be released and, although this is not an option which is attractive to everyone, it is nevertheless one to be made available, given appropriate regulation and monitoring of commercial schemes.

The retirement village option is one for homeowners or those with substantial assets. Models have been presented in Chapter 3 suggesting that this option could be extended at least into the middle-income range and that rental retirement village options could be considered. CoHousing is a further option for groups of older people able and willing to organise themselves. Pilot schemes could help to make this option more ‘visible’ as an option for New Zealanders.

## **Non-homeowners**

Groups of low-income older people who have not achieved homeownership or accumulated substantial assets at present have fewer current options – mainly HNZC or TLA pensioner rentals or their equivalent in the voluntary or private sectors. Figures presented in Chapter 4 indicate a potential shortfall in the number of homes available in the public sector under various scenarios.

The choices are: a supply-side response (acquire more houses to add to the public housing stock to cope with the additional demand); a demand-side response (attempt to change/modify behaviour to alleviate the shortfall); or a combination of both of the above. Changing behaviour essentially means improving the attractiveness of homeownership. Issues with maintenance, repairs and adaptation are relevant also for renters. Partnerships with other housing providers in the voluntary sector, as well as the private market, have a role to play in alleviating the shortfall in appropriate housing for older people. A role for health providers

(DHBs and private sector) in such partnerships should not be overlooked. These comments reinforce the need for co-ordination and leadership amongst the potential partners.

Forms of rental housing for older people are discussed in Chapters 3 and 4. The Abbeyfield and ‘social village’ models have many strengths for older people who retain reasonable levels of independence and can be applied in either rental or ownership forms (or using new types of tenure). Cluster housing, bearing in mind the location needs of older people – proximity to public transport, shops, churches, health services and recreational opportunities – seems preferable to very large-scale developments. These run the risk of cutting people off from family and community links. The social village model also appears to have appeal for Maori and Pacific elders, especially if it encourages cultural expression and preserves inter-generational links.

## **Care, support and health outcomes**

Where people need high levels of care and support, mainstream housing, or the alternatives just discussed, may not be suitable, unless appropriate design standards and assistive technology have been applied. ‘Sheltered’ or ‘intermediate’ housing has been in existence since the endowment of alms houses in the Middle Ages, but ageing in place policies and de-institutionalisation have led to proliferation of intermediate forms of housing for older people. This may be defined as housing with special design or location features for older people, linking housing and care and support services. It may be purpose-built or converted/adapted housing, although there are limitations on adaptation. For example, multi-storey housing with shared facilities may not be appropriate.

‘Sheltered’ housing can take the village or clustered forms, but very high needs suggest the provision of extra-care housing, following models found in Europe. There is evidence that older people, even with very high levels of dependency, can be maintained in housing which maximises their opportunities for autonomy and social contact and that these values (intangibles) are highly prized by older people. Chapters 2 and 4 show the high fiscal costs of residential care and the projected high demand for this service if present trends remain unchanged. From both the individual’s and government’s perspectives, therefore, alternatives to residential care have much to recommend them and should be investigated and trialled in New Zealand. However, our conclusions emphasise that such alternatives must ensure a net benefit on the intangibles. The fiscal cost savings should not be seen as an argument for ‘de-institutionalising’ the older population in the absence of suitable alternative accommodation.

## **Cost/Benefit of Future Options**

The cost-benefit analysis suggests that, from the perspective of the government, the impact on the costs of care and support for older people is the largest factor. From the perspective of the individual, the best option will arise from a combination of impacts on intangibles such as independence, proximity to care and support needs and social interaction, as well as security. The importance of intangibles indicates that a best or 'preferred option' cannot, and should not, be pre-ordained. This reinforces the findings from the consultation exercise, when participants stressed that housing should fit individual requirements and also emphasised the need for flexibility, given the difficulties in projecting future trends.

## **Risk**

The primary risk surrounding the future projections relates to the *no change in tenure patterns* assumption. Given recent declines in homeownership rates and affordability, this assumption could be seen as somewhat optimistic. If homeownership continues to fall, then requirements for public sector rental accommodation for older people will be further increased. In addition, the *no change* outcomes sees a further 43,000 older people entering the private rental market, underlining concerns for quality of this housing stock and its appropriateness for older people. This prospect cannot be viewed with optimism, certainly for low-income groups, unless measures to ensure quality and appropriateness of the housing stock are instituted.

## **Ideas for the future**

Numerous ideas, concepts and models related to housing for older people have been discovered in the course of this research. To summarise, the following warrant further investigation, considering, in particular, their applicability in the New Zealand context.

- Lifetime homes design standards and universal design. These could be piloted, in the first instance, in the design of public housing and housing built with public funds.
- Quality marks and energy efficiency ratings (especially for heating and insulation). Adopting such ratings could encourage landlords to improve their properties, making them more marketable to prospective tenants.

- Home improvement assistance. Older people need information and assistance with home renovations, including emotional and practical advice when considering options for moving, and then assistance through the process. They need this possibly more than other groups because many are widowed, have no close family willing and available to help, and have to cope with health problems. This could be a role for voluntary organisations with government funding assistance.
- The potential of using equity release to fund home maintenance, renovations, adaptations and improvement.
- Homesharing, which may give older people help in their homes, cover overnight (but not as a substitute for homecare) and enhanced security. This also could be managed by voluntary groups.
- CoHousing is an opportunity for groups who have common interests and want to live together. This may be a good option for the young-old, but should still adopt universal design and be located in proximity to services.
- More research is needed on how assistive and smart technology could be applied in housing for older people, to improve levels of comfort and security. Smart technology could be especially useful in dementia care, where people need secure accommodation, but should not be a replacement for human contact.
- Secondary buildings – the ‘granny flat’ model - may require a closer examination, which would ask why this model has not become common and if it could be improved.
- Overseas examples show how extra-care housing can substitute for residential care and be consistent with encouraging independence and positive ageing. This suggests a ‘housing based’ model of eldercare, replacing institutional approaches.
- Village options seem appropriate to meet older people’s needs for social contact, security and support services. These could usefully follow the social village model rather than being segregated communities, targeting lower income people. Clustering housing for older people and using existing facilities as ‘hubs’ for wider service delivery will produce economies of scale.

## **A mix of housing provision?**

A variety of responses is needed to meet the range of housing needs for older people, both now and in the future. Any balance or mix of assistance also needs to take into account the relative effectiveness, cost and acceptability of various options as they are developed and adopted. Given limited resources and competing priorities across policy areas, the government must decide where it should invest to maximise social and economic wellbeing. When deciding the best mix of housing interventions it must assess the value (including human, social, environmental and economic factors) that can be gained from a particular approach over the short and the long-term. It needs to weigh this against the direct costs of that approach and the potential costs and benefits of other forms of spending (for example, health or education).

## **A continuum framework of housing options**

Linking life course stages to the likelihood of increasing need for care and support, as people age, suggests a continuum of housing types and options for older people. This will range from remaining in a long-term family home through to supported accommodation and increasing levels of care up to rest home and hospital levels. This is conceptualised in the OECD's 2003 report (p200) as a range of housing types linked to levels of frailty (see Table 42).

It also fits with the 'continuum of care' concept set out in the *Health of Older People Strategy*. This means that 'an older person is able to access needed services at the right time, from the right place and from the right provider' and that provision is coordinated and responsive, with smooth transitions between services and levels of care.



There can be no single answer. Nor can we simply present a range of attractive housing options without discussing how these could realistically apply in New Zealand. A range of issues surrounding housing options, such as funding and management must also be considered. Good housing is only one element in wellbeing. Attention to future accommodation options for older people is important, not only because they are a growing segment of the population, but also because of their special needs, which cannot be separated from the housing environment.

The role of government (with the dual aims of minimising net fiscal costs and improving overall wellbeing) is to ensure that there is a co-ordinated approach between housing providers (Housing New Zealand Corporation, local authorities, voluntary organisations, private sector) and providers of health services, care and support (DHBs, private and voluntary sector). This co-ordination necessarily requires cross-sector strategies as well as leadership, with a reduction in the 'silo' approach to funding and continuing emphasis on the 'whole of government' approach to policy and the associated determination of funding.

These imperatives are recognised in current policy, especially in the Positive Ageing, Health of Older People and Housing Strategies. The report can be seen as contributing to the achievement of the objectives of these strategies through the provision of policy-oriented information and analysis. This advice, however, is aimed not only at central government agencies, but also at local government and organisations in the private and voluntary sectors which are involved in housing and other support for older people, or who represent their interests.

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## Appendix 1. Consultation Programme

The research programme included a consultation phase, during which information on accommodation options for older people was sought from a range of stakeholders. These included representatives from agencies in central and local government, in the voluntary and private sectors. In addition to a programme of face-to-face and telephone interviews, carried out by members of the research team, some organisations gave written feedback, based on the questions listed in Appendix 2. Special programmes of consultation took place in the Maori community, undertaken by Tautari Huirama of Te Mauri Te Kore Ltd., and in the Pacific community by Margaret Southwick, Director of the Pacific Health Research Centre at Whitireia Community Polytechnic. A case study in Taranaki included consultations with local stakeholders, by Velma McClellan of Research and Evaluation Services Ltd. (see list of persons consulted, below). Notes on the Maori and Pacific consultations are at the conclusion of this appendix.

Two Round Table meetings were held in Wellington on June 1 and 4, 2004. These included people who had already been consulted and others with an interest in the project. The following is a sector-based list of people who were consulted and the organisations which they represent. Attendees at the Round Table meetings are indicated with an asterisk\* and additional attendees are listed separately.

### People consulted

#### *Central government*

Louise Dooley, Ted Gallen, Jane Yoong, Maria McNeill\*, Geraldine Canham-Harvey, Office for Senior Citizens

Judy Glacken, Stephen Jacobs and Paulette Finlay, Health of Older People, Sector Policy Directorate, Ministry of Health

Jim Nicholas, Paula Comerford, Housing New Zealand Corporation

Jane Von Dadelszen, Ministry of Women's Affairs

Sai Lealea, Manager, Va'a Makisi, Alice Letts, Ati Mamoe, Ministry of Pacific Islands Affairs

Colin Lewis and Harry Tam, Te Puni Kokiri

Daryl Collins and Tim Roper, The Treasury

*Local government*

Rob Dally\*, Kevin Bennett\* Lyn Campbell, Lesley Symington, Christchurch City Council  
Stephen Cayley, New Plymouth District Council

*District Health Boards*

Karina Kwai\*, Hutt Valley DHB  
Benedict Hefford\*, Capital and Coast DHB  
Gill Coe, Canterbury DHB

*Voluntary sector*

Bruce Kaye\*, National chairperson Abbeyfield, Nelson  
Libby Clements\*, Third sector housing steering group  
Jeff Sanders, Raye Boyle\*, Karen Rhind\*, Wesley Community Action and Wesleyhaven  
John Gibson, CEO, Age Concern Wellington  
Warick Dunn, Wellington Masonic Villages Trust  
Jeremy Nash\*, Chairman Waimarino Rest Home Trust  
Niel Groombridge\*, Presbyterian Support Central  
Graham Stairmand\*, National President Grey Power,  
Ann Robertson, National Service Co-ordinator, Services for Older People, Salvation Army  
Anne Delamere, Maori Women's Welfare League  
Kerry Dalton\*, CEO, Age Concern New Zealand  
Max Reid\*, General Manager, Te Hopai Trust  
Garry Salmons, Manager, Compassion Housing, Upper Hutt

*Private sector*

Tiopira Rauna\*, Ihimaera Rauna Associates  
Boyd Klap\*, Chairman, Sentinel Ltd.  
Maurice Mehlhopt, Manager, Lifestyle Security, Christchurch  
Paul Morris, General Manager – Developments, Summerset

*Other attendees at the Round Table Meetings*

Judith Le Harivel, Rebecca Kiddle, Housing New Zealand Corporation  
John Litton, Wellington Masonic Villages Trust  
Margaret Guthrie, Age Concern Wellington  
Pam Daniel, Ministry of Women's Affairs

Colin Lewis, Te Puni Kokiri  
Mike Reid, Local Government New Zealand  
Kathryn Haliburton, Ministry of Health  
Bernie Richmond, The Salvation Army  
Terrence Aschoff, Centre for Housing Research Aotearoa New Zealand

*Roundtable attendees from the research team*

Ganesh Nana  
Judith Davey  
Virginia de Joux  
Mathew Arcus  
Velma McClellan  
Tautari Haurima

## **Maori Consultation**

The Maori focus groups included 11 older people, 6 women and 5 men in two groups, at Papakura Marae and Kawhia. There were also interviews with 4 health care givers and 4 kaumatua advocates. In addition, information was provided by:

John Ranga, kaumatua worker in Kawhia  
Sharon Pickering, Pa o Te Ora, Hikuranga  
Daphne Dawson, health worker/support for kaumatua in Papakura  
Keita Dawson, Te Manaaki o nga Kaumatua  
Walley Martin, kaumaatua in Rawene  
Timu Minamina, kuia from Taranaki  
Tiopira Hauna, Ihimaera Rauna Associates.

There was also an interview with and written input from Te Puni Kokiri and further interviews with Maori informants in the New Plymouth case study. Ann Delamere also provided useful comment. In some cases, people and organisations approached were unwilling to provide information and/or be quoted.

## **Pacific Consultation**

A convenience sample of Pacific people in Auckland and Wellington participated in two focus groups to provide a Pacific perspective of housing needs for older Pacific people living in the New Zealand. Participants were recruited through Pacific community networks and attendance and participation in the focus group was taken to be informed consent. The Wellington group convened on Monday 15<sup>th</sup> March and the Auckland group on Thursday the 18<sup>th</sup> March. Twenty-three people attended the Wellington session and fifteen people attended the Auckland session. The Wellington group included Samoan, Tongan, Cook Islands, Fijian, Tokelauan, and Tuvaluan people. The Auckland group included Samoans, Tongan and Cook Island people. The age range of both groups was between late twenties to mid forties with the participants being predominantly in their early to mid forties. The sessions each took three hours to complete.

To ensure each person had an opportunity to contribute their perspective the workshops were randomly divided into groups of four or five people who worked through the questions and recorded the range of responses on poster paper. We then reconvened and went through the questions again with each group reporting back. Participants were asked to think about the questions in two ways: firstly in relation to their knowledge of older Pacific people's housing situations now, and secondly how things may change over time. Participants found the first task easier than the second. For some participants, it seemed that this was the first time they had seriously thought about what their housing needs might be in the future as they themselves aged.

As well as the focus group interviews Margaret Southwick spoke with Terongo Tekii a Cook Islands community leader on the 7<sup>th</sup> April to discuss with him the plans the Cook Islands Community in Porirua have for developing culturally appropriate elder housing.

### **Wellington Workshop participants**

T.Logotuli	E.Pereria
E.Atonio	L.Mailo
M.Finau	L.Nanai
T.Fiu	J.Sione
L.Green	M.Talamaivao
M.Isaako	F.Tautau
K.Lal	E.Tavita
J.Logologo	S.Vaa
F.Magele	M.Waidamudamu

F.Pauta  
S.Laban  
M.Smith

A.Kupa  
N.Begam

### **Auckland Workshop participants**

I.Vaofusi  
O.Tefono  
V.Baker  
T.Kuresa  
O.Lokahi  
L.Sua  
B.Ranfurly

A.Talealau  
T.Peseta  
S.Tameifuna  
V.Meredith  
M.Liutai  
K.Tuagalu

### **The New Plymouth Case Study**

As part of the New Plymouth case study, the following were consulted:

Simon Cayley, Community Development Advisor, NPDC

Aroha Chamberlin, Cultural Development Co-ordinator, NPDC

Gavin Thorley, Property Assets Manager, NPDC

Leighton Littlewood, Client Services Officer, NPDC

Alison Rumble, NPDC Councillor

John Cunningham, Chairperson, Positive Ageing Committee

Andrea Corbett, Chairperson, Positive Ageing Research Centre, Western Institute of  
Technology

Mina Timutimu, Elder Protection Co-ordinator, Maru Wehi Hauora

Olwynne Bailey, Secretary/Manager Te Ati Kaumatua Housing Accommodation.

## **Appendix 2. Questions used in consultation phase**

### **Housing for Older People Project – State Sector, Local Authority and NGO Consultation**

*Overall question – What would be an appropriate mix of short and long term public and private accommodation investments that will meet the needs of a rapidly ageing New Zealand population and that will improve the quality of life for older people, especially those with low incomes, Maori, Pacific People and women?*

1. Please could you describe the current provision of housing for older people (numbers, location, services provided, eligibility, waiting lists?) provided by your organisation?
2. Has your organisation considered the issue of home maintenance for low-income older homeowners?
3. What is the significance of variations across your or the regions – proportion of older people, concentrations of special groups (Maori, low income renters)?
4. What are the policy options for local government/state sector/NGOs that would provide better supported accommodation options for older people in terms of the costs and benefits?
5. What role could/should local authorities /state Sector / NGOs play in providing housing for older people, especially those in specified groups?
6. What is the future of pensioner housing in your region – how could it be adapted to meet the objectives of government policy?
7. How could models of partnerships between public, private and voluntary sector groups –be applied?
8. The overseas literature indicates that size of the accommodation is not a central concern for older people but rather they have a focus and need for manageability of their environment which has resulted in overstock and underuse of one-bedroom and bedsitter accommodation overseas. With this issue in mind how appropriate are the current stocks of social housing for the needs of older and older disabled people?
9. Is there a need to invest in new housing stock specifically aimed at older renters, or is there a need to refurbish and remodeling current housing stock? If either of these options are needed what in your view is the most appropriate and viable alternative?

What would the funding issues associated with either of these options be for your organisation? Which agency should take the lead in being responsible for stocktaking both the number and quality of rental housing for older people? Which agency should take the lead in funding modifications or conducting new build?

10. What do you see are the barriers to the implementation of supported accommodation options for older people? At the structural level how could such housing be funded and what agency should take responsibility for the management and co-ordination of the buildings and the employment of an onsite manager / warden?
11. Alongside the structural aspects of supported housing is the need for parallel support services to ensure the viability of this form of housing. Again what agency do you think should take on the management and responsibility for these services and how best should these be funded?
12. In conjunction with services for supported accommodation, what is your view on the current services that are provided to older people who elect to remain in their homes? What is being done well and what aspects could be improved? Is the provision of home modification services adequate for the needs of older people and what particular concerns are raised for older renters who require specialized adaptations in order to remain living at home?
13. What is your view on the availability of and accessibility to information about the support services, housing options, and home repair and modification services? Is the current information system appropriate and effective? If not how could it be managed better?

## Housing for Older People Project – Maori Consultation

*Overall question – What would be an appropriate mix of short and long term public and private accommodation investments that will meet the needs of a rapidly ageing New Zealand population and that will improve the quality of life for older people, especially those with low incomes, Maori, Pacific People and women?*

1. What are the special needs (including cultural needs) of older Maori?
2. How well are they served by currently available housing options (urban or rural)?  
Options include:
  - mainstream housing (metropolitan, urban, rural),
  - kaumatua housing – How appropriate and effective is the kaumatua flats (housing adjacent to marae) concept?
  - Maori/iwi organisations either administering or planning housing
  - Maori groups working with local authorities.
3. Maori academic, policy, and service providers are questioning assumptions about the role of whanau in caring for older Maori. The tradition/expectation that older Maori will be supported by younger whanau may need to be revisited as trends are changing, eg:
  - Higher proportion of older Maori living alone or with a spouse only
  - Increased life expectancy for Maori
  - Larger number of older Maori.
4. Are there currently financial, physical, psychological or social difficulties for older Maori arising from the nature of their accommodation?
5. In what ways are housing and health linked for older Maori?
6. Could you please comment on the implications of the rural location of older Maori and the ageing of the cohort that has moved out of cities.
7. Looking towards to the future when there are likely to be many more older Maori, what type of accommodation options would lead to a healthier and more resilient older Maori population?
8. In relation to the housing models you were suggesting, what are the social and economic costs and benefits for older Maori (individuals)?
9. Are there benefits to the community of community-based supported accommodation options for older Maori people?

## **Housing for Older People Project – Pacific People Consultation**

*Overall question – What would be an appropriate mix of short and long term public and private accommodation investments that will meet the needs of a rapidly ageing New Zealand population and that will improve the quality of life for older people, especially those with low incomes, Maori, Pacific People and women?*

1. What are the special needs (including cultural needs) of older Pacific People? What are they and how well are they served by currently available housing options?
2. Are there currently financial, physical, psychological or social difficulties for older Pacific People arising from the nature of their accommodation?
3. Will retaining older people in extended family households remain as common as now?
4. What is the impact, for older people, of home ownership levels among Pacific communities?
5. What is the significance of life expectancy, retirement age and health status differences among Pacific People compared to the rest of the New Zealand population?
6. In what ways are housing and health linked for older Pacific People?
7. Looking towards to the future when there are likely to be many more older Pacific People, what type of accommodation options would lead to a healthier and more resilient older Pacific population?
8. In relation to the housing models you were suggesting, what are the social and economic costs and benefits for older Pacific People (individuals)?
9. Are there benefits to the community of community-based supported accommodation options for older Pacific People?

## **Appendix 3. Summary tables**

Summary tables referring to information in Chapter 2 provided in this appendix.

Note, in line with standard *Statistics New Zealand* practice in regards to confidentiality, all individual cell data from the Census is random rounded to a unit of 3 - consequently, the sum of components may not add to the stated total.

**Table 43 Number Aged 65+ Resident in Private Dwellings by Annual Household Income**

65+	All private dwellings		Own home		Rent from TLA		Rent from HNZ		Rent from other		NEC tenure	
	Total	Living alone	Total	Living alone	Total	Living alone	Total	Living alone	Total	Living alone	Total	Living alone
<b>ALL ETHNIC GROUPS</b>												
<b>Total</b>												
low income	73,215	67,914	49,152	45,504	5,796	5,751	3,798	3,402	11,343	10,347	3,126	2,910
moderate income	156,327	36,285	129,801	28,794	1,734	825	3,528	471	16,362	4,797	4,902	1,398
higher income	107,868	9,342	92,676	7,803	165	51	1,503	39	10,935	1,104	2,589	345
income not stated	69,687	16,581	38,667	7,767	1,587	1,245	3,525	945	9,984	3,066	15,924	3,558
<b>TOTAL</b>	<b>407,097</b>	<b>130,122</b>	<b>310,296</b>	<b>89,868</b>	<b>9,282</b>	<b>7,872</b>	<b>12,354</b>	<b>4,857</b>	<b>48,624</b>	<b>19,314</b>	<b>26,541</b>	<b>8,211</b>
<b>Females</b>												
low income	52,599	50,049	36,177	34,455	3,423	3,399	2,880	2,655	7,839	7,362	2,280	2,178
moderate income	81,249	26,244	67,101	21,054	870	453	1,872	351	8,724	3,348	2,682	1,038
higher income	51,612	5,652	44,052	4,725	72	21	879	27	5,310	660	1,299	219
income not stated	39,729	12,708	21,354	6,261	996	834	2,229	762	6,072	2,457	9,078	2,394
<b>TOTAL</b>	<b>225,189</b>	<b>94,653</b>	<b>168,684</b>	<b>66,495</b>	<b>5,361</b>	<b>4,707</b>	<b>7,860</b>	<b>3,795</b>	<b>27,945</b>	<b>13,827</b>	<b>15,339</b>	<b>5,829</b>
<b>Males</b>												
low income	20,616	17,865	12,975	11,049	2,373	2,352	918	747	3,504	2,985	846	732
moderate income	75,078	10,041	62,700	7,740	864	372	1,656	120	7,638	1,449	2,220	360
higher income	56,256	3,690	48,624	3,078	93	30	624	12	5,625	444	1,290	126
income not stated	29,958	3,873	17,313	1,506	591	411	1,296	183	3,912	609	6,846	1,164
<b>TOTAL</b>	<b>181,908</b>	<b>35,469</b>	<b>141,612</b>	<b>23,373</b>	<b>3,921</b>	<b>3,165</b>	<b>4,494</b>	<b>1,062</b>	<b>20,679</b>	<b>5,487</b>	<b>11,202</b>	<b>2,382</b>

low income : annual household income < \$15,000; moderate income between \$15,000 and \$30,000; higher income > \$30,000.

**Table 44 Maori Aged 65+ Resident in Private Dwellings Aged 65+ by Annual Household Income**

65+	All private dwellings		Own home		Rent from TLA		Rent from HNZ		Rent from other		NEC tenure	
	Total	Living alone	Total	Living alone	Total	Living alone	Total	Living alone	Total	Living alone	Total	Living alone
<b>MAORI</b>												
<b>Total</b>												
low income	3,057	2,550	1,554	1,269	363	351	333	267	624	516	183	147
moderate income	4,710	675	3,294	411	123	57	336	45	738	123	219	39
higher income	3,612	159	2,673	96	12	6	237	3	585	39	105	15
income not stated	4,587	990	2,496	357	153	123	498	120	1,014	258	426	132
<b>TOTAL</b>	<b>15,966</b>	<b>4,374</b>	<b>10,017</b>	<b>2,133</b>	<b>651</b>	<b>537</b>	<b>1,404</b>	<b>435</b>	<b>2,961</b>	<b>936</b>	<b>933</b>	<b>333</b>
<b>Females</b>												
low income	1,824	1,530	957	780	165	168	234	189	366	303	102	90
moderate income	2,379	417	1,656	258	69	30	186	30	360	75	108	24
higher income	1,818	81	1,329	48	9	0	135	6	285	18	60	9
income not stated	2,694	666	1,410	246	96	69	327	84	618	183	243	84
<b>TOTAL</b>	<b>8,715</b>	<b>2,694</b>	<b>5,352</b>	<b>1,332</b>	<b>339</b>	<b>267</b>	<b>882</b>	<b>309</b>	<b>1,629</b>	<b>579</b>	<b>513</b>	<b>207</b>
<b>Males</b>												
low income	1,233	1,020	597	489	198	183	99	78	258	213	81	57
moderate income	2,331	258	1,638	153	54	27	150	15	378	48	111	15
higher income	1,794	78	1,344	48	3	6	102	-3	300	21	45	6
income not stated	1,893	324	1,086	111	57	54	171	36	396	75	183	48
<b>TOTAL</b>	<b>7,251</b>	<b>1,680</b>	<b>4,665</b>	<b>801</b>	<b>312</b>	<b>270</b>	<b>522</b>	<b>126</b>	<b>1,332</b>	<b>357</b>	<b>420</b>	<b>126</b>

low income : annual household income < \$15,000; moderate income between \$15,000 and \$30,000; higher income > \$30,000.

**Table 45 Pacific People Aged 65+ Resident in Private Dwellings by Annual Household Income**

65+	All private dwellings		Own home		Rent from TLA		Rent from HNZ		Rent from other		NEC tenure	
	Total	Living alone	Total	Living alone	Total	Living alone	Total	Living alone	Total	Living alone	Total	Living alone
<b>PACIFIC PEOPLE</b>												
<b>TOTAL</b>												
low income	720	444	243	168	84	81	237	99	123	78	33	18
moderate income	1,095	108	540	51	48	18	303	15	168	18	36	6
higher income	2,190	15	1,308	12	6	0	480	0	324	0	72	3
income not stated	2,826	147	1,005	45	66	39	984	27	555	15	216	21
<b>TOTAL</b>	<b>6,831</b>	<b>714</b>	<b>3,096</b>	<b>276</b>	<b>204</b>	<b>138</b>	<b>2,004</b>	<b>141</b>	<b>1,170</b>	<b>111</b>	<b>357</b>	<b>48</b>
<b>Females</b>												
low income	435	267	147	105	36	30	159	75	72	42	21	15
moderate income	603	63	294	36	24	6	177	9	87	12	21	0
higher income	1,242	6	714	6	6	0	288	0	195	0	39	0
income not stated	1,647	108	576	24	27	30	600	30	324	12	120	12
<b>TOTAL</b>	<b>3,927</b>	<b>444</b>	<b>1,731</b>	<b>171</b>	<b>93</b>	<b>66</b>	<b>1,224</b>	<b>114</b>	<b>678</b>	<b>66</b>	<b>201</b>	<b>27</b>
<b>Males</b>												
low income	285	177	96	63	48	51	78	24	51	36	12	3
moderate income	492	45	246	15	24	12	126	6	81	6	15	6
higher income	948	9	594	6	0	0	192	0	129	0	33	3
income not stated	1,179	39	429	21	39	9	384	-3	231	3	96	9
<b>TOTAL</b>	<b>2,904</b>	<b>270</b>	<b>1,365</b>	<b>105</b>	<b>111</b>	<b>72</b>	<b>780</b>	<b>27</b>	<b>492</b>	<b>45</b>	<b>156</b>	<b>21</b>

low income : annual household income < \$15,000; moderate income between \$15,000 and \$30,000; higher income > \$30,000.

**Table 46 Number Aged 85+ Resident in Private Dwellings by Annual Household Income**

85+	All private dwellings		Own home		Rent from TLA		Rent from HNZ		Rent from other		NEC tenure	
	Total	Living alone	Total	Living alone	Total	Living alone	Total	Living alone	Total	Living alone	Total	Living alone
<b>ALL ETHNIC GROUPS</b>												
<b>Total</b>												
low income	9,369	9,006	6,402	6,135	708	708	333	318	1,452	1,389	474	456
moderate income	10,506	5,346	8,286	4,092	153	102	195	66	1,368	801	504	285
higher income	6,435	1,236	5,412	981	15	6	66	6	690	177	252	66
income not stated	7,143	2,949	3,855	1,518	207	168	246	96	1,083	555	1,752	612
<b>TOTAL</b>	<b>33,453</b>	<b>18,537</b>	<b>23,955</b>	<b>12,726</b>	<b>1,083</b>	<b>984</b>	<b>840</b>	<b>486</b>	<b>4,593</b>	<b>2,922</b>	<b>2,982</b>	<b>1,419</b>
<b>Females</b>												
low income	7,368	7,188	5,007	4,872	552	552	279	270	1,143	1,113	387	381
moderate income	6,294	4,068	4,905	3,114	102	81	117	51	870	606	300	216
higher income	3,702	798	3,114	624	9	3	48	6	390	120	141	45
income not stated	4,731	2,442	2,493	1,275	150	138	174	87	735	465	1,179	477
<b>TOTAL</b>	<b>22,095</b>	<b>14,496</b>	<b>15,519</b>	<b>9,885</b>	<b>813</b>	<b>774</b>	<b>618</b>	<b>414</b>	<b>3,138</b>	<b>2,304</b>	<b>2,007</b>	<b>1,119</b>
<b>Males</b>												
low income	2,001	1,818	1,395	1,263	156	156	54	48	309	276	87	75
moderate income	4,212	1,278	3,381	978	51	21	78	15	498	195	204	69
higher income	2,733	438	2,298	357	6	3	18	0	300	57	111	21
income not stated	2,412	507	1,362	243	57	30	72	9	348	90	573	135
<b>TOTAL</b>	<b>11,358</b>	<b>4,041</b>	<b>8,436</b>	<b>2,841</b>	<b>270</b>	<b>210</b>	<b>222</b>	<b>72</b>	<b>1,455</b>	<b>618</b>	<b>975</b>	<b>300</b>

low income : annual household income < \$15,000; moderate income between \$15,000 and \$30,000; higher income > \$30,000.

